GENERAL MEDICAL COUNCIL

PROFESSIONAL CONDUCT COMMITTEE

On:
Monday, 19 January 2004

Held at:
Barnett House
53 Fountain Street
Manchester M2 2AN

Case of:

PATRICK VERNON FINN COSGROVE MB BS 1968 Lond
(Day One)

Committee Members:
Professor Norman Mackay (Chairman)
Mr Christopher Brightmore
Dr Alison Hamilton
Mr John Matharu
Dr Belinda Stanley
Mr Richard Briden (Legal Assessor)

MR D MORRIS, of Counsel, instructed by Messrs RadcliffesLeBrasseur, appeared on behalf of Dr Cosgrove, who was present.

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

(Transcript of the shorthand notes of TranscribeUK
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THE CHAIRMAN: Good morning. I now formally announce that the case we are about to hear is that of Dr Cosgrove. Dr Cosgrove is present and is represented by Mr David Morris, counsel, instructed by RadcliffesLeBrasseur, solicitors. Mr Richard Pearce, counsel, instructed by Field Fisher Waterhouse, solicitors, represents the Council.

Mr Morris, I understand you wish to make a submission at this point.

MR MORRIS: Sir, not at this point but very shortly – I think the Inquiry should be opened by the reading of the charge. I am looking at Rule 24 of the Rules and it was after the reading of the charge that I was going to submit an objection on a ground of law to the charge. So perhaps at this stage I would invite the Committee Secretary to read the charge and then I can explain my position.

THE CHAIRMAN: I thought we were, perhaps, considering a request that we had an adjournment until 2 pm, but if you want to read the charges...

MR MORRIS: I shall be making that submission but it might assist in my explanation of background to why I am asking for time until 2 pm if at least the charge was read.

MR PEARCE: I am content with that way of proceedings. If you are minded so to proceed I do, however, have an application to amend the charge in various, I hope, minor ways.

THE CHAIRMAN: We will take these amendments at this stage since we are, it would appear, going to read the charges.

MR PEARCE: I am obliged, sir. Two of them, in effect, are not even amendments to what you have in front of you because they have already been altered. In fact, your copy does not reflect the original Notice of Inquiry in two ways: one is that the original numbering was wrong and your copy now has been correctly renumbered; secondly, in the original Notice of Inquiry at charge 9a on the third line of my copy, where it says “Dr Helen Thomas”, it now says “Chubb”. Chubb is correct and it ought so to read.

The two substantive applications that I have, sir, relate first of all to paragraph 8---

THE CHAIRMAN: Before we leave 9a, is there another name that is to be changed? I thought Dr Melinda Thomas was Miranda Thomas.

MR PEARCE: Miranda Thomas, sir, yes – I am sorry.

On 8a this is where the renumbering of the paragraph caused confusion. It should say, “In the letter referred to in paragraph 7c above”.

In paragraph 10a, now having seen medical records it is clear that the date of this appointment with Patient G was 24 February 2003, so rather than reading “in or around January 2003” I invite you to amend it to say “on or around 24 February 2003”.

THE CHAIRMAN: Thank you. Can I just check that in head of charge 1 it is the Bristol Priority Clinic?
MR PEARCE: Yes.

THE CHAIRMAN: Dr Cosgrove, can I ask you to stand, please?

THE COMMITTEE SECRETARY: The Committee will inquire into the following charge against Patrick Vernon Finn Cosgrove, MB BS 1968 Lond; MRCS Eng LRCP Lond 1968 SR:

"That, being registered under the Medical Act,

‘1. At all material times, you were practising as a Consultant Child and Adolescent Psychiatrist working in private practice at the Bristol Priority Clinic;

‘2. a. On 3 May 1996, you saw Patient A, a child who had been diagnosed as suffering from Attention Deficit Hyperactivity Disorder (ADHD),

b. You prescribed drugs to Patient A as follows:

i. between May 1996 and May 1999, you prescribed methylphenidate (Ritalin),

ii. by July 1996, you had increased the prescribed dose of Ritalin to 62.5 mg per day,

iii. in May 1998, you increased the daily dosage of Ritalin to 100 mg per day,

iv. by May 1999, you had increased the dose of Ritalin to 130 mg per day,

v. from July 1996, you prescribed an additional daily dosage of risperidone at 1 mg per day,

vi. by November 1998, you had in addition prescribed clonidine as a night time sedative,

c. Having so prescribed, your monitoring of Patient A was irresponsible in that

i. you did not see Patient A in person between May 1996 and May 1999,

ii. you did not make an adequate assessment of Patient A’s weight,

iii. you did not monitor Patient A’s growth,
iv. you did not warn Patient A’s mother that sudden withdrawal of clonidine could have a deleterious effect on Patient A’s blood pressure,

v. you did not advise Patient A’s General Practitioner (GP) to monitor Patient A as above;

‘3. a. On 1 December 1999, you saw Mr B as a private patient and diagnosed that he was suffering from ADHD,

b. On 3 December 1999, you wrote a letter about that consultation to Dr Humphreys, Mr B’s GP, which letter you copied to Dr K Al-Shabner and to Mr and Mrs B,

c. In that letter, you stated as follows:

i. that Mr B had seen a doctor who might have been Dr Al-Shabner,

ii. that the doctor whom Mr B had seen had been rude and unhelpful,

iii. that the doctor whom Mr B had seen had been scruffily dressed,

iv. that the doctor whom Mr B had seen knew nothing about ADHD,

v. that the doctor whom Mr B had seen was guilty of medical negligence,

vi. that the doctor whom Mr B had seen had demonstrated professional incompetence,

d. The comments that you made in the said letter were

i. unprofessional,

ii. unsustainable,

iii. likely to cause the reader to doubt Dr Al-Shabner’s knowledge and/or skills;

‘4. a. On 27 May 1999, you saw Master C, a nine-year old boy, as a private patient,

b. On 29 May 1999, you wrote a letter to Master C’s GP about the consultation, sending a copy of the letter to Dr Karin Moses, Consultant Child Psychiatrist responsible for the treatment of Master C under the
NHS,

c. The said letter requested that Master C’s GP prescribe him risperidone and Ritalin,

d. The letter did not contain any advice for Master C’s GP about appropriate monitoring of Master C whilst he was taking those drugs,

e. Your failure to provide such advice to Master C’s GP was

i. irresponsible,

ii. not in the best interests of Master C;

'5. a. On 7 July 1999, you wrote a letter to Dr Karin Moses, which letter you copied to Master C’s parents and his GP,

b. In that letter, you stated

i. that Dr Moses was likely to deny some or all of what Master C’s parents had told you about her treatment of Master C,

ii. that Dr Moses had seen Master C only once whilst he was a day patient on the children’s psychiatric unit at St Cadoc’s Hospital, Caerleon, Newport, during which period Master C was getting worse and worse when he should have been getting better and better,

iii. that Dr Moses owed Master C’s parents an explanation as to why she had not prescribed Ritalin during the time that Master C was a patient at the children’s psychiatric unit,

iv. that when Dr Moses first saw Master C he was aged 5 years old, and that she made no diagnosis and that she had done nothing that resulted in alleviating Master C’s malfunctioning,

v. that nothing that Dr Moses had done when she saw Master C aged 5, 6 and 7 years had prevented his behaviour causing him to be asked to leave two schools and to be admitted to St Cadoc’s Hospital,

c. The comments that you made in the said letter were

i. unprofessional,

ii. unsustainable,

iii. likely to cause the reader to doubt Dr Moses’ knowledge and skills;
‘6. a. In or about May 1996 you saw Master D, a ten-year old boy, as a private patient,
   b. You diagnosed Master D as suffering from ADHD,
   c. You prescribed Ritalin for Master D,
   d. Your examination of Master D on that occasion was inadequate in that
      i. you did not weigh him,
      ii. you did not take his blood pressure,
   e. You subsequently spoke to Master D’s mother by telephone, following which you prescribed risperidone,
   f. You failed to make proper arrangements for monitoring the effects of the treatment which you provided for Master D;

‘7. a. In or around August 2000, Oxfordshire Mental Healthcare NHS Trust carried out an investigation into a number of features of the treatment of a patient of the Trust, Patient E,
   b. On 29 September 2000, Miss Wendy Samways, Complaints Manager at the Oxfordshire Mental Healthcare NHS Trust, wrote to you requesting copies of your medical records concerning Patient E and enclosing signed authorisation for the release of the records,
   c. By a letter dated 3 October 2000, you replied to Miss Samways that you would not supply the medical records,
   d. Your failure to supply the notes as requested was
      i. inappropriate,
      ii. unprofessional;

‘8. a. In the letter referred to in paragraph 7c above, you also stated as follows:
   i. that Patient E had been given inadequate care by an employee of the Oxfordshire Mental Healthcare NHS Trust,
   ii. that the investigation being carried out might end in a whitewash of such inadequate care,
   iii. that you believed the investigation to be a cover up of grossly inadequate care received by Patient E from the Trust,
iv. that the investigation was programmed to ensure that the Trust was not criticised at all or only criticised in a minor way,

b. The comments set out in the letter were

i. unprofessional,

ii. unsustainable,

iii. likely to cause the reader to doubt the knowledge or skills of the employees of the Oxfordshire Mental Healthcare NHS Trust who treated Patient E;

9. a. By a letter dated 17 November 2000, concerning a patient Mr F, which you sent to his GP, and copies of which you sent to Dr Helen Chubb, Consultant Psychiatrist at the Cardiff and Vale NHS Trust and Dr Miranda Thomas, SHO in psychiatry at the same Trust, you stated that you had diagnosed Mr F as suffering ADHD and that you had prescribed him Ritalin,

b. That letter did not contain any advice to the prescribing GP about the monitoring of Mr F,

c. In the letter, you stated as follows:

i. that Mr F had not felt that Dr Thomas had listened to him when he talked about his personal understanding of ADHD,

ii. that Dr Thomas had stated that a “concentration problem is for messy kids”,

iii. that the comment alleged to be made by Dr Thomas was an ignorant comment,

iv. that both Dr Thomas and Dr Chubb were arguably guilty of medical negligence in knowing less about ADHD in adults than Mr F,

v. that Dr Thomas had made an assertion of “therapeutic nihilism” in saying “the consultant thinks that you have got a personality disorder which is not treatable”,

vi. that if Mr F responded to treatment for adult-type ADHD, it would indicate that Dr Thomas and Dr Chubb were negligent in not listening to Mr F and in not knowing about ADHD as a real condition in adults, leaving room for formal complaint to the Fitness to Practice Directorate of the General Medical Council,
The comments that you made in the said letter were

i. unprofessional,

ii. unsustainable,

iii. likely to cause the reader to doubt the knowledge or skills of Dr Chubb and Dr Thomas;

‘10. a. On or around 24 February 2003, you saw a 4 year old child, Patient G, as a private patient,

b. Thereafter, you prescribed Ritalin and risperidone to Patient G,

c. By May 2003, you were prescribing

i. Ritalin at 25 mg per day,

ii. risperidone at 0.625 mg per day,

d. Having so prescribed, your monitoring of Patient G was irresponsible in that

i. you did not make an adequate assessment of Patient G’s weight,

ii. you did not monitor Patient G’s growth,

iii. you did not adequately monitor any possible side effects;

‘11. a. On or around 16 July 2003, you saw Patient H as a private patient,

b. On 19 July 2003, you wrote to Patient H’s GP, which letter you copied to Patient H’s parents and to Dr Dover, a Consultant Psychiatrist who had treated Patient H,

c. In that letter you stated amongst other things

i. that, if Dr Dover did not believe in ADHD, he might have difficulty in being revalidated by the General Medical Council,

ii. that Dr Dover should have studied Patient H’s school reports,

iii. that Dr Dover had behaved in a professionally unacceptable manner by not arranging a second opinion when asked to do so,

b. The comments that you made in the said letter were

i. unprofessional,
ii. unsustainable,

iii. likely to cause the reader to doubt the knowledge or skills of Dr Dover;’

And that in relation to the facts alleged you have been guilty of serious professional misconduct.”

THE CHAIRMAN: You may sit down, Dr Cosgrove.

MR MORRIS: Sir, as I indicated before the charge was read, Rule 24(2) of your Rules says that:

“After the reading of the charge or charges the practitioner may submit any objection on grounds of law to any charge or part of a charge and any other party may reply to such an objection.”

Sir, I wish in due course to make an application under 24(2) that the Inquiry be stayed because to allow otherwise and to allow the Inquiry to proceed would be an abuse of process of this Committee.

I am not in a position now to proceed with that submission. I will tell the Committee why and explain the indulgence that I seek from them. May I also add that in addition to that submission I secondly make an alternative submission, which only arises if you reject my first submission in relation to the whole inquiry. The second submission relates to head of charge 2, which concerns patient A. My submission in relation to that again is that to allow that head of charge to proceed to inquiry would be an abuse of process for the reason that the parents of patient A have specifically expressly in writing forbidden or refused to grant consent to either Dr Cosgrove or those investigating this matter on behalf of the General Medical Council to have access to the patient’s medical notes. You will see the nature of the charge, that it concerns the monitoring of patient A and an allegation that the monitoring by Dr Cosgrove was irresponsible.

My submission, in a nutshell, will be that it would be impossible to allow Dr Cosgrove a fair hearing in relation to that allegation without allowing him access to the patient’s notes, that is to say his General Practitioner notes, the notes made by the doctor who saw him, Dr Holmes, and Dr Cosgrove’s own private notes in relation to that patient.

Can I turn back to my first and primary submission, that the whole of the inquiry should be stayed? It arises from a particular head of charge, namely head of charge 6, which concerns the patient Master D. Head of charge 6 originates from information provided to the General Medical Council by an organisation called the Citizens’ Commission on Human Rights, whose Executive Director is a Mr Brian Daniels. The Citizens’ Commission on Human Rights is an organisation, and I quote from headed notepaper of that organisation,

“…which was established in 1969 by the Church of Scientology to investigate and expose psychiatric violations of human rights.”
Under the aegis of the Citizens' Commission on Human Rights information was given to the General Medical Council about the treatment by Dr Cosgrove of patient D. The mother of patient D purported to write to the General Medical Council in the form of a complaint. She thereafter signed a letter giving permission for the disclosure of her son’s medical records.

Sir, I can at this stage help the Committee if I just show you the copy of that letter, together with, for comparison purposes, letters written by the patient’s mother in 1996 at a time, as you will see from the charge, when Dr Cosgrove was seeing the patient.

THE CHAIRMAN: We will label these D1 and D2.

MR MORRIS: Sir, I think in terms of chronology it would probably make sense if the 1996 letters were labelled D1.

THE CHAIRMAN: Agreed. *(Same handed)*

MR MORRIS: You and your Committee may perhaps notice two matters when you compare the letters written in 1996 and the letter written on 11 December 2001.

THE CHAIRMAN: The letter I have is August 2000.

MR MORRIS: I am sorry, I have got the wrong letter. It is 18 August 2000. First of all, the name of the patient’s mother is spelt differently. Secondly, from a lay perspective it would appear that the signatures of the mother on the letters in 1996 are in a different handwriting to the signature on the letter of 18 August 2000. We are at this moment having an expert look at the handwriting available from the patient’s mother in 1996 and the handwriting available for the person who has signed that letter and other documents in 2000 and 2001 in order to get an expert handwriting opinion on whether or not that handwriting is by the same hand or by a different hand.

I am confident that I will have information on that before two o’clock this afternoon. That is one of the reasons why I am seeking the Committee’s indulgence in this regard. If I can put it in a nutshell, the basis of my submission in due course will be that under the aegis of the Church of Scientology’s organisation, the Citizens’ Commission on Human Rights, a complaint or information has been provided which is fraudulent, inasmuch as it does not come from whom it purports to come from, namely the mother of patient D.

The knock on effect of that, in my submission, will be this in relation to the whole of the notice of inquiry: that in relation to patients A to F, that is to say all but the last two patients, you will note that the treatment dates state 1996, 1999 and 2000, or at least the dates are 2000. In relation to those heads of charge, the information or complaints that were provided to the General Medical Council or derived or originated in 1999 or 2000, as did the complaint from the Citizens’ Commission on Human Rights. The complaints outwith the Citizens’ Commission complaint from A to F effectively lay dormant thereafter and no action was taken, certainly on the face of the documentation that has been disclosed to the defence so far.
The Citizens’ Commission wrote on a number of occasions to the General Medical Council culminating with a final letter in August 2002 making inquiries and providing further information in relation to the information that had originally been given in the year 2000. On 26 September 2002 the Solicitor to the General Medical Council wrote to the Registrar formally notifying him of the information that had been provided in relation to the heads of charges A to F.

It would appear to the defence that that temporal link between the letter received or sent in August and, if I may put it in the vernacular, the ball began to roll as far as this investigation and this inquiry were concerned in the following month of September, when all the other complaints had remained in a dormant state gives rise to the reasonable suspicion on the part of the defence that it was as a result of Citizens’ Commission on Human Rights complaint which we say is of fraudulent origin that the remainder of these charges came to be progressed and, on that basis, that it would not be fair, because of the manipulation of the investigative procedure of the General Medical Council by the Commission to allow this inquiry to proceed.

That, in a nutshell, is the basis of the submission that I will be seeking to make, but there is the problem of the handwriting evidence that I wish to canvass. There is also a request that was made to the Council which has not yet been answered and I am seeking an answer, as to the disclosure of any internal documentation within the General Medical Council as to what happened following the receipt of the final letter from the Commission in August 2002, leading up to the letter from the solicitor of 26 September 2002. Those two matters obviously are going to cause a hiatus, and it was for that reason that I seek the indulgence of the Committee to be allowed to delay the beginning of my submission until 2 pm at the earliest. I am very much aware that the Committee would not wish to waste time unnecessarily.

What I can say is that in making the full submission I will be making reference to a report that was commissioned by Parliament on the Church of Scientology in about 1969, and the report was written by a Member of Parliament and a Queens Counsel Mr Foster which became to be known as the Foster report. Members of the Committee may or may not have heard of it or indeed may or may not be familiar with it. I will during the course of the submission be making reference to passages in that report to seek to explain to the Committee the nature of the Church of Scientology and its particular attitude to psychiatrists to give a necessary background to the submission I make, which otherwise might appear to be an extraordinary one, namely an allegation of fraud. It might assist if the Committee were to have that report, which has been copied now - it is quite a bulky document – so that they could look at it if they are prepared to grant the indulgence of an adjournment until 2 o’clock, to be able to look at it in the interim so that time could be saved in that way. It is being copied at this very moment; it is not ready yet.

THE CHAIRMAN: If it becomes available we will label it D3.

MR MORRIS: When it does come I will hand it to the Committee.

THE CHAIRMAN: Mr Pearce.

MR PEARCE: Sir in explaining our position may I simply state in one sentence I hope in
response to the outline of the submission that my silence in respect of the response does not mean that we accept any of the premises that my learned friend has already stated. However, we perfectly understand the rationale behind the matter being put back to 2 o’clock. We have no objection to that. We are currently seeking to establish whether there is anything previously in the documentation of the type referred to by Mr Morris and we should have the answer to that clearly before 2 o’clock. In terms of the Foster report I should say I have not had an opportunity to see that and would welcome that opportunity. Thirdly sir may I say this, that anticipating that there were to be submissions today that were likely to be relatively lengthy and complex, we took the liberty of not warning witnesses to attend believing that it was unlikely that the Committee would reach that stage in any event, so you can be comforted in one thing, that they are not inconvenienced by any delay there may be today.

THE CHAIRMAN: Looking round the panel I suspect there is no problem about deferring to 2 p.m. Legal Assessor?

THE LEGAL ASSESSOR: The only question I would ask is if in the Foster report there are there any particular passages that you would like the Committee refer to. It looks a rather bulky document, if we can be steered to the relevant part.

MR MORRIS: That is what I was going to do.

(The Enquiry into the Practice and Effects of Scientology (The Foster Report) was labelled D3 and handed to the Committee)

MR MORRIS: One thing will become immediately apparent and it is a regrettable fact that the report that you have is not paginated. On the other hand it is broken up into sections which are fairly readily accessible, and sir looking at the content sheet at the front what I would invite the Committee to concentrate on in terms of the introduction into the background to the enquiry, a, b and c, with reference perhaps only to (i) Australia where a significant enquiry was held I think in the state of Victoria preceding the Foster report, and that came to be known as the Anderson enquiry.

Then, to understand the nature of the enquiry that Sir John Foster conducted, if I could specifically refer you to section 2, and obviously the Committee might be interested in section 3 under the heading “What is Scientology?” without perhaps going into the function of the service with reference to (a) The Founder, (b) The Organisation in the United Kingdom, and then I think perhaps if I could direct the Committee directly to section 7, “Scientology and its Enemies” in section 7 at paragraph 174. That is another way of navigating around this document. It is put in paragraphs. At paragraph 174 which is at the beginning of chapter 7 “Scientology and its enemies” they are numbered under 4 headings: (i) Scientologists who have defected from the cause, (ii) Anyone outside Scientology who expresses doubt as to its truth, value, efficacy, or sincerity, (iii) Psychiatrists, (iv) Communists. I need not concern you with the last category, but perhaps if the Committee would care to look at the first three categories under that heading, those are the sections which will be of particular interest.

THE CHAIRMAN: Perhaps just for the record I should check that none of the members of the panel has links with the Church of Scientology. There are no links. We formally
now adjourn until 2 p.m.

(The Committee adjourned until 2 p.m.)

THE CHAIRMAN: Mr Morris, just before the break this morning I asked the Members of the Panel if anyone was a member of Scientology or had links with the Church of Scientology. The answer at that stage was no, but one member of the Panel involved in previous employment had cause to look at some work that Scientology was doing in relation to drug addiction, as I understand it, and had some contacts with Scientology at that stage and has spoken and referred to the work in subsequent meetings. That is not the extent of the links between any Panel Member and the Church of Scientology, but I thought that for the record and in case there was any perception of bias I should raise it with both of you just to check if you have any objections we will take them on board and if there are no objections then the Panel Member can continue.

MR MORRIS: I am grateful. We both had notes from the learned Legal Assessor setting out the nature of the contact. Perhaps, for the record, I ought to say what I understand, so I get it accurately, what the nature of the contact was, which was contact with an organisation called Narconom, which is a subsidiary or an organisation allied to or part of the Church of Scientology; that the Panel Member, out of his official duties, visited that organisation and in particular rehabilitation centre working with addicts and formed a favourable view of the work that that organisation was doing with addicts, such that when he was no longer acting in his official capacity and had retired from that official capacity he spoke publicly in support of this particular programme at meetings organised by the organisation or on behalf of the organisation in Germany.

I have obviously discussed that with Dr Cosgrove and taken his views and the view he comes to – and it is a view that I share – is this, that while that information cannot begin to ground a suggestion that this particular Panel Member would show or is biased in relation to the hearing of this case, there is left a perception of bias which can only be dealt with by the Member stepping down from this particular Committee.

I am sure you will be advised in due course as to how to approach what is the proper test for assessing whether or not there is a perception of bias. It is, in my submission, where a reasonably robust member of the public would perceive that there was a risk that if that particular person remained on the Committee there would be or there could be said to be a realistic risk of bias in that Committee’s deliberations resulting from the presence on the Committee of that person.

The reasons why it is submitted that there is a perception of bias in this case is that the contact that the Committee Member had with this Church of Scientology organisation was not limited to purely professional observation. It went further than that: he took a view of that organisation; he took a favourable view and, furthermore, he spoke in favour of that organisation (the Narconom organisation) in public. In the context of the overall organisation, the Church of Scientology, I hope the Committee will accept, having read parts of the inquiry into that organisation by Sir John Foster that it is an organisation where the view that is taken by those in power there that “Either you’re with us or you’re against us”. It is in that context that Dr Cosgrove – and I accept and support him in this submission – is concerned that by speaking publicly in favour of an ancillary organisation
within the umbrella of the Church of Scientology a perception of bias might arise.

I would only add this, that Dr Cosgrove instructs me that from his perception he too had knowledge of the Narconom organisation and would not accept that its work is wholly good and acceptable. It is for that reason that, regrettably, we have come to the conclusion that there is a perception of bias here that can only be dealt with by the withdrawal of that Committee Member.

THE CHAIRMAN: Thank you very much. Mr Pearce.

MR PEARCE: Sir, may I say first of all that it was, in our submission, quite right that your Committee Member should draw attention to this matter. It is a rather, perhaps, in some ways obscure connection with a particular organisation but in the circumstances of this case it was desirable and he did quite properly disclose that information.

Sir, our position is this. It is vitally important, in our submission, that this hearing does not become, nor should it be seen to be, a trial in any way of the Church of Scientology or any aspect of that church. However, it is apparent from what my learned friend has already had to say and apparent, if I may say so, from those passages of Sir John Foster’s report to which he has referred us, that his submissions at an early stage are going to involve, one may anticipate, a robust criticism of that church.

As I say, the Committee may not feel it necessary to itself come to any view upon the criticism of the Church of Scientology but, be that as it may, it would appear to form part of my learned friend’s submissions. He knows how he is going to put his submissions on the issue of abuse and in that context it seems to us that given the view taken by Dr Cosgrove and on his behalf by his legal team, it would be wrong of us to seek to persuade you that, notwithstanding my learned friend’s submissions, the particular Member of the Committee ought to continue to sit. Therefore, we would invite you, in the circumstances, to accede to the submission made on behalf of Dr Cosgrove.

THE CHAIRMAN: Legal Assessor?

THE LEGAL ASSESSOR: My advice to the Committee is it is ultimately a question for you to decide. However, I would urge you to take into account the fact that both parties have asked you to come to a conclusion, effectively, that there might be a perception of bias if this particular Member were to continue sitting.

The actual test for perceived and opposed to actual bias, I would summarise in this way: are the circumstances of the case such that would lead a fair-minded and informed observer to conclude there was a real possibility that the Committee was biased unconsciously in this case? That hypothetical observer is one, I would suggest, who is a member of the public, who is well informed, that is not complacent and neither is he excessively suspicious. So my advice to you is you should apply that test as to whether or not this particular Member should continue to sit and hear this case.

I do stress that nobody is suggesting that the Member is actually biased in any shape or form, it is just a question of whether there might be a perception of someone watching these proceedings, a danger of unconscious bias.
Perhaps the only other point that should be taken into account is the views of the actual Member himself, which I believe is that he is agreeable to withdrawing if there is objection by either party, which there has been. I do not think I need say any more on that particular point.

THE CHAIRMAN: Do either of you wish to come back on anything the Legal Assessor has said?

MR PEARCE: No, sir.

MR MORRIS: No, sir.

THE CHAIRMAN: We will now go into camera for a short period and strangers will withdraw.

STRANGERS THEN, BY DIRECTION FROM THE CHAIR, WITHDREW AND THE COMMITTEE DELIBERATED IN CAMERA

STRANGERS HAVING BEEN READMITTED

THE CHAIRMAN: Mr Pearce and Mr Morris, you will notice that we are one down. It was considered that it would be better if the member concerned stood down from the rest of the hearing. It is the view of the panel that there is no conscious bias on the part of the person concerned. Any perception of bias would be in relation to the possibility of unconscious bias and his words of approval were in relation to the drug rehabilitation programme, rather than the Church of Scientology itself. Taking into account all the factors before the panel, decision was that it would be wiser if he were to excuse himself from the rest of the hearing.

MR MORRIS: Sir, I am grateful and I know Dr Cosgrove would wish to associate himself with what you have said about there being no conscious bias. Can I update you on what has been going on this morning during the indulgence you have kindly granted us? A handwriting expert has looked at D1 and D2 and has made an oral report that has been communicated to us here that there is no evidence to link the handwriting on the GMC letter, D2, and the signature on that letter to the handwriting that we see on the three letters that form part of the 1996 letters or matters that were part of Dr Cosgrove’s notes.

When she says that there is no evidence to link them, she is effectively saying that in her professional opinion there is absolutely no evidence that the 1996 signatures were written by the same person as the author of the 2000 signature, in other words, they are by different hands. She says that when using every criterion of professional comparison, whether it is proportion, shape or size, everything in her opinion is different. She further says that it is highly unlikely that a person of the age that Master D’s mother was at the time, that is to say, I anticipate, somewhere in her forties, would so radically alter her signature in that space of time so that it was different in every handwriting aspect.

She is going to prepare a written report to that end, which will be done during the course
of today and should be available by the end of today. The significance of that evidence, in my submission, is high and it is a matter that the Committee would no doubt like to investigate further before coming to a conclusion on my abuse submission. The sort of investigation that I would anticipate would be appropriate in these circumstances would be for the person who the Council says is the mother of the patient concerned, who makes the complaint about Dr Cosgrove, to give evidence in relation to this matter, as well as the expert handwriting witness. The expert handwriting witness is available tomorrow and Wednesday, but I understand from Mr Pearce that the purported mother, if I can call her that from our side, of Master D is not available until Wednesday morning.

The other development this morning has been the disclosure by the Council of internal letters and memoranda dealing with the period running up to the letter written the Council’s Solicitor to the Registrar on 26 September 2002. On the face of that documentation that I and Dr Cosgrove have seen, there is nothing expressly set out there which would suggest that there were any steps taken by Mr Daniels or anyone else within the Human Rights Commission or the Church of Scientology which had an obvious effect on the decision to reactivate these complaints that have been made in 1999 and 2000.

What I do say on behalf of Dr Cosgrove is this: that that on its own is not sufficient. Because of the nature of the organisation, which I hope you have had a chance to gather from your short perusal of passages from the inquiry into the practice and effects of scientology, it would be impossible without hearing from this witness, the ostensible mother of Master D, who is acting, as we know, under the aegis of the Human Rights Commission, to know what the extent of the Commission’s efforts to influence the General Medical Council was. We know that there were many letters from Mr Daniels and the Commission, although you do not have them before you, to the General Medical Council chasing up the complaint they made between August 2000 and August 2002. We also know from the Foster report that the organisation, and that must include the Commission, which is an essential function within the organisation, is an organisation that, in order to propagate its views about medicine and psychiatry in particular has gained membership, if I can put it as neutrally as that, within organisations as set out by Sir John Foster, namely the British Medical Association and the Royal College of General Practitioners and is an organisation that is prepared to seek to take over wholesale medical organisations. By way of example, at paragraph 186 in the section dealing with the enemies of the organisation, Sir John Foster notes,

“The scientologists attempted to take over the National Association for Mental Health, a UK body which is affiliated to the World Federation of Mental Health by joining it in large numbers with the object of voting a majority of scientologists on to its council.”

That was an attempt that was exposed. The Association resisted and the scientologists took action by seeking injunctive relief to restrain the Association from holding an annual general meeting. That legal action was defeated.

That is the nature of the organisation. My submission is that it would be impossible to come to a firm conclusion, a safe conclusion in relation to the possibility that this organisation had an improper subversive effect on the Council, whether consciously or subconsciously on the part of the Council had an improper subversive effect on it until
the evidence is heard from that particular witness.

In short, given that we have here prima facie evidence – I say that on the basis of the oral report from our handwriting expert – that there are fraudulent signature or there are fraudulent signatures in documentation sent to the General Medical Council and that one of those signatures appears on the actual letter of complaint in relation to head of charge D, my submission of abuse should not proceed until we have had an opportunity to hear from the witness in question.

THE CHAIRMAN: Mr Pearce.

MR PEARCE: Sir, I take it at this stage that the issue we are dealing with is as to when arguments relating to abuse of process ought to be determined. The reality of the situation is that if that is to be after you have had the opportunity to hear from the mother of patient D, that must be on Wednesday because that is the only day when she will be available to attend this week. To give a little background, she lives and works in a city some considerable distance from here. She has child care issues as well and everything has been organised on the assumption that Wednesday will be the day for her to give evidence, which was our plan. That is why that is so.

Sir, I do ask you to look with care at the manner in which this submission is being structured in order to consider whether in fact you do need to hear from that witness in order to decide on the submission. If I follow the submission correctly, it runs in the following manner: first of all, it is said charge 4 is, for want of a better expression, fraudulent, and it is so because it is based upon a complaint which, at least prima facie…

THE CHAIRMAN: Is it charge 4 or charge 6?

MR PEARCE: It is charge 6. Charge 6 is a fraudulent charge in the sense that it is based upon a complaint which, prima facie, it is said has been signed by somebody other than the person who purports to make that complaint. I draw attention immediately to a number of points about that. You will have noted with care the way my learned friend has recited the report of the handwriting expert. She has not in fact said in the oral conclusions that have been communicated that the letters are not signed by the same person. She has said that there is no evidence that they were signed by the same person. That may be a distinction that matters. It may well be that were you to hear from the parent of Master D there would be a perfectly adequate explanation for why the two signatures appear sufficiently different to lead to that conclusion. One only has to speculate for a moment on a number of possible explanations that are consistent with it being not in any sense whatsoever fraudulent or dishonest.

Let us assume for a moment, simply for the purpose of this argument, that you were persuaded, upon hearing from the mother of Master D that that charge is fraudulent in the sense in which my learned friend suggests it may be. So what? Clearly that would affect you views on that particular charge. One can well understand that point. What about the broader issue of abuse of process?

We come to the next stage in the reasoning. The next stage in the reasoning is, as I understand it, that that alleged fraud in relation to that charge, coupled with the nature of
the Church of Scientology which has through this Commission a link with the bringing of that charge, that connection can be taken to be a basis for a conclusion that these charges in their entirety are only pursued because of fraudulent charge 6.

That conclusion, if you consider it, will rest upon a number of considerations. You will read what the Foster report has to say. You will have noted the older one gets the less distant the 1960s and 1970s seems, but we are talking about a report that is thirty years old plus. We are talking about matters which are historic. One is only seeing one viewpoint. I know I have already said I do not invite you to try the issue of the conduct of the Church of Scientology, but I know that the Church of Scientology itself would defend its position and produce literature to seek to defend its position and say, with due respect, that Sir John Foster got matters wrong in his report. There are differences of opinions on those lines.

Even if, purely for the sake of dealing with these submissions, the Church of Scientology is, as is categorised by my learned friend, an organisation that will use any means to achieve the end of attacking psychiatry, where does that take us? Where is the evidence that the Church has in fact influenced the prosecution of this case? You make take it from my learned friend’s submissions and concessions that there is nothing in any documentation that he has seen that we have been able to disclose to him that suggests any such involvement or influence, nor is there any other documentation that we, for our part, are aware of that could be disclosed that might possibly reveal any other conclusion.

MR PEARCE: One has that stage as well. I invite you to say, how is hearing from D’s mother assisting in any event in assessing whether there has been as between the church generally and the commission, the individual author of the letter, there has been some undue influence upon the GMC? There won’t be any more evidence once you have heard from D’s mother on this particular point, so we say they fail at that stage. But if I may say so sir I am attempting for a moment to deal with the question, not the merits of the submission, even if my learned friend were to get over that hurdle and were to show that some pressure unduly in some way influenced the decision to bring these charges, even then we say that does not mean that it is appropriate to stay the charges. These are professional disciplinary charges with individual reasons for each allegation, and in our submission the Committee must be able to hear the evidence and determine the facts in relation to each charge. Even if it were true that there was in some sense a bad motivation or some bad faith, we still submit that that would not be a ground to stay these proceedings. It follows from all of that sir that in our submission hearing from D’s mother will not assist in determining the stay application, save possibly, I conceive this, in respect of a stay application specific to ground 6 where really the merits of the stay would overlap so much if you found that that evidence was fraudulent. You may think charge 6 is bound to collapse whether it is stayed or where ever we have to drop the case however it is dealt with, and we certainly would not seek to stand in the way of any renewed application, be it on Wednesday or at any other stage given the specific on charge 6, but in terms of a stay of the general case in so far as the doctor has a proper case to put, in our submission it is proper to deal with that submission now and to deal with that submission and not invite the Committee to hear from D’s mother.

Sir, may I raise one very practical issue about this, that this should not, if you are otherwise persuaded by what my learned friend has to say, this should not dissuade you
from doing what he says but if you are minded in the balance this is a proper
consideration for you to bear in mind, the practical consequences of what my learned
friend is suggesting is that there is nothing as I see it for this Committee to do tomorrow
that we are already therefore 2 days down, 6 days left. From our point of view we have
lined up witnesses with a view to calling D’s mother on Wednesday and also an expert
witness Professor Taylor. Professor Taylor is only available on Wednesday. We have
had great difficulty with his availability but we have ensured he is available on
Wednesday, and it is our concern I must say that in order to deal with abuse submissions
including evidence from D’s mother, the evidence of D’s mother live as it were actually
on the charges if the case goes ahead and the evidence of Professor Taylor, in my
submission that is a very long day’s work for this Committee. The chances are that on
Wednesday I would be in a position to say to the Committee from our point of view we
ask you to do it because we have no other way of ensuring that these witnesses can be
heard and accommodated, so that is a practical consideration about effectively not
wasting a day and creating difficulties on Wednesday but on the merits and the substance
of it, for the reasons I have said in my submission, you will not be more assisted by an
application to stay than from hearing it from the documents as are. Unless I can assist
further.

MR MORRIS: Briefly if I can respond, in relation to the nature of the evidence from the
handwriting expert, I think my learned friend is perhaps taking a semantic point of view
when he says that the report that there is nothing to link the two signatures is not to say
that they were not made by one and the same person. Obviously she is unable to say that.
I suppose it is possible that the person may have changed her signature so radically in
that period of time. I don’t suppose the handwriting expert could exclude that as a
possibility, but I think she would characterise it as a very remote possibility and of course
one has to factor in my submission the fact that that signature where there is no evidence
of connection between it in handwriting terms between that and the earlier 1966
signatures, is spelt differently itself, a significant fact in itself.

Turning to the consequences if it is accepted that there is a prima facie case that the
submission of the complaint in charge 6 is fraudulent, my learned friend asked whether or
not there is any connection between that and the decision to proceed with the other
charges outside head of charge 6. He is right in saying that there is nothing on the face of
the documentation that I have been provided with, but I submit that he is bold in
suggesting that there will be nothing from the person who is going to come on
Wednesday to give evidence purportedly as the mother of Master D. If that person can
throw light on to the circumstances that surround the putting to paper of a fraudulent
complaint, made fraudulent by a fraudulent signature, we say given the nature of the
organisation under which the aegis of which that complaint was made, who can say as to
what light may not be cast as to the efforts of that organisation in bringing the remainder
of the charges to life in relation to Dr Cosgrove? It would be dangerous in our
submission, given the nature of that organisation, without hearing all the appropriate
evidence to come to that conclusion about which you must be sure before deciding to
proceed without that evidence to hear this submission. And then my learned friend goes
on to say and even if it is established that there is some bad faith here which lies behind
the bringing of the other charges, that is not sufficient on its own to found a basis for
submitting that there should be a stay of the whole enquiry. I don’t accept that as a
matter of law and I am happy to take the Committee to passages in Archbold in relation to
that. Perhaps I should at this stage if I can take the learned legal adviser to paragraph 4-54 of the 2004 edition if he has it.

THE LEGAL ASSESSOR: I have edition 3.

MR MORRIS: It is 4-54. There has been no change I am glad to say between that and the 2004 edition. The authors there are saying, this is the principles governing the exercise of the jurisdiction of the abuse of process, and if I can just go back to the heading which in the 2004 edition is at 4-48, abuse of process jurisdiction, the general setting for it is set in Connelly against DPP 1964 House of Lords decision, Lord Devlin added a fifth ground to the list set out in another case where particular criminal proceedings constitute an abuse of the court’s process. What all their lordships do seem to agree upon is that the court has a general and inherent power to protect its process from abuse. This power must include a power to safeguard an accused person from oppression or prejudice. The views expressed in Connelly were considered Obiter in DPP v Humphrys in 1977, again a House of Lords case, only Lords Dilhorne, Salmon and Edmund-Davies considered the point. Lord Salmon and Lord Edmund-Davies concurred with the views expressed by Lord Devlin and Lord Pearce in Connelly while Lord Dilhorne supported the narrower approach adopted by Lord Morris. Lord Salmon was then quoted:

“I respectfully agree with my noble and learned friend, Viscount Dilhorne, that a judge has not and should not appear to have any responsibility for the institution of prosecutions; nor does he have any power to refuse to allow a prosecution to proceed merely because he considers that, as a matter of policy, it ought not to have been brought. It is only if the prosecution amounts to an abuse of the process of the court and is oppressive and vexatious that the judge has the power to intervene. Fortunately such prosecutions are hardly ever brought, but the power of the court to prevent them is, in my view, of great constitutional importance and should be jealously preserved. For a man to be harassed and put to the expense of perhaps a long trial and then given an absolute discharge is hardly from any point of view an effective substitute for the exercise by the court of the power to which I have referred.”

And if I can take you back to the principles governing the exercise at 4-54, The power to stay proceedings for abuse of process has been said to include the power to safeguard an accused person from oppression or prejudice – that is Connelly – and has been described as a formidable safeguard developed by the common law to protect persons from being prosecuted in circumstances where it can be seriously unjust to do so. An abuse of process was defined in the case of Ho Chi Min v R 1992 – a Privy Council case – as something so unfair and wrong that the court should not allow a prosecutor to proceed in what in all other respects is a regular proceeding.

It says that in Baring plc, a case of 1999 decided in the Court of Appeal (Civil Division), it was said:

“In the context of proceedings under section 6, the Company Directors Disqualification Act of 1986, that a court may stay
proceedings where to allow them to continue would bring the administration of justice into disrepute among right thinking people, and that this would be the case if the court was allowing its process to be used as an instrument of oppression, injustice or unfairness.”

If I can just take the learned Legal Assessor to paragraph 4-56. I hope that is the same in his edition.

THE LEGAL ASSESSOR: The majority decision of *R v Horseferry Magistrates Court ex p Bennett*.

MR MORRIS: Thank you. That decision has now made it clear that the doctrine of abuse of process is not limited to situations where the defendant could not receive a fair trial. The accused in that case has been brought to this country as a result of collaboration between authorities here and abroad, and in disregard of extradition procedures. The doctrine was held to apply in such a situation even though the matters complained of would not prevent a fair trial and even though it would not be unfair to try the accused if he had been returned to this country through lawful extradition procedures, Lord Griffith said that the court had the power to interfere with the prosecution because the judicial acceptance of responsibility for the maintenance of the rule of law embraces a willingness to oversee executive action and to refuse to countenance behaviour threatened by the basic human rights and the rule of law. It was the function of the high court to ensure that executive action was exercises responsibly as Parliament intended. If therefore it came to the attention of the high court that there had been a serious abuse of power it should express its disapproval by refusing to act on it. Lord Bridge said there is no principle more basic in any proper system of law than the maintenance of the rule of law itself.

In the *R v Mullen* [1999], again a Court of Appeal decision, it was said that the speeches in ex parte inclusively established that proceedings may be stayed in the exercise of the court’s discretion not only where a fair trial is impossible but also where it can be contrary to the public interest and the integrity of the criminal justice system that a trial should take place. Guidance was also given as to the sort of matters that may affect the exercise of discretion.

Sir what I submit in the light of that is if indeed there is bad faith demonstrated in relation to the bringing of the charges other than head of charge 6, there is ample authority in my submission for that granting properly a stay on the grounds of abuse of process, and that lack of bad faith doesn’t have to be found in the heart of the prosecuting body; it can take effect even if the body itself is an unwitting victim of that bad faith in my submission, and that is established at paragraph 4-63a. Again I hope it is the same in the learned Legal Assessor’s edition. It is headed “Matters relating to complainant or witnesses.”

THE LEGAL ASSESSOR: Yes it is the same.

MR MORRIS: Under that heading matters relating to complainant or witnesses, the orders say this:

“An abuse of process exists where the plaintiff in civil proceedings is in effective control of criminal proceedings against the same
defendant to the extent that the prosecution are unable to exercise independently their prosecutorial duties”

And two cases are cited there. Then another example is given:

“If a bank is the ultimate complainant and ‘prosecutor’, there is a heavy burden on that bank to make available to the prosecution, for onward disclosure to the defence (including privileged documents) relevant to the issues, and failure to do so might well compromise the ‘integrity of the proceedings’; where necessary the prosecution can produce documents that have been suitably sanitised so as to preserve customer confidentiality.”

So what my submission is, that if a complainant is exercising an effect on the prosecuting body, and the comparison here would be between Mr Daniels and the Commission as the complainant, and the GMC as the prosecuting body, if it is having such an effect on that body that itself can amount of an abuse of process which merits the staying of the enquiry. My submission is that if such bad faith can be established, and I accept that the burden is on the defendant, the burden and the standard of proof on the balance of probabilities, if that can be established, that affords good grounds for a stay. It is impossible in my submission to come to a firm conclusion on that issue until such time as we have heard the evidence in relation to that particular issue. That will include the person who signed that document or whose name was purported to have signed it.

Can I turn to the practical issue? I accept that it may cause difficulties on Wednesday. It may lead to a long day in order to accommodate Professor Taylor if it is necessary to call him. That is a hardship in my submission that the Committee and everyone appearing before it should be prepared to face in order to give proper justice in this case to Dr Cosgrove.

THE CHAIRMAN: Legal Assessor?

THE LEGAL ASSESSOR: I must confess I do find this a little difficult. My understanding is that both counsel are agreed that the burden is on the Respondent to make out a case on abuse of process. As I understand it, the application is that this witness can be called, presumably by the GMC, on the question of whether there is in fact an abuse of process in bringing the whole inquiry. Am I still with everybody here?

MR MORRIS: I am not proposing to call any evidence over and above the witness; I am not proposing to adduce any evidence beyond the evidence that would be adduced should the mother, or purported mother, of Master D give evidence. So what I am saying is that within her evidence there may be some light that can be cast upon the role of the Commission over and above that which is available on the documents. On the basis of the documentation that we have so far, we have evidence of the complaint and of it being
pursued on a regular basis with the Council. Beyond that, I am not going to call any further evidence.

There is documentation that is not yet before the Committee, which I do propose to put, dealing with such issues as, for example, the fact that the issue about the apparent difference in handwriting between the signature of the complaint made by the ostensible mother of Master D in August 2000 and the handwriting of the patient’s mother in 1996, together with the fact that the name in that signature was spelt differently was brought to the attention of the Council on 25 January 2001 when Mr Panting of the Medical Protection Society wrote to the General Medical Council about it and asked for investigations to be made. Those investigations were not made for 21 months and there was no response to that letter.

So whether or not any conclusion can be drawn from that is a matter for the Committee, obviously, but that is an item of additional documentary evidence that I will be putting before the Committee in due course during the hearing of this, but as far as live oral evidence, the answer is no – apart, of course, from the handwriting expert.

MR PEARCE: Could I just come in on that point, sir? I appreciate, given where it is agreed the burden of proof lies that one does get into a difficult area here, but for our part our inclination, I have to say – and I do not think this is necessarily assisted by any textbooks or authority – our information is that if you thought that that witness might say something that might assist my learned friend’s case we would be minded to say we ought to call her – to concede, effectively, what my learned friend says.

Our reasoning, if I may say so, is quite simply this. If it were not dealt with in that way, she might in any event say something in the course of ordinary evidence that supported the contention for a submission and in that supposed scenario you would be in a position of having rejected my learned friend’s submission, then finding later on further down the line that there was in fact relevant material and you might need to reconsider it. If you think she is capable of saying something that will enlighten your assessment of the submission, then we would be minded to accept that we ought to call her and that my learned friend should cross-examine her.

THE LEGAL ASSESSOR: I am grateful for that. The reason I raised it was that because, if you accept the burden is on you, ordinarily it would be for you to call the evidence. I was a little confused when the Council were talking about it, but Mr Pearce, very fairly, is saying he is prepared to call the witness so she can be cross-examined by Mr Morris.

MR PEARCE: Yes.

THE CHAIRMAN: So basically what Mr Pearce is conceding is that your request that we postpone any further discussion until Wednesday morning goes ahead.

MR PEARCE: I was not conceding that, sir, I am sorry. What I was conceding was that if you took the view that that lady’s evidence might help you then I do concede, effectively, the adjournment until Wednesday morning. I remain of the view, for the reasons I have said already, that it will not help you, whatever she says, even if my
learned friend establishes the height of the case, as he put it, is not going to assist you on the terms of the stay.

THE CHAIRMAN: Legal Assessor?

THE LEGAL ASSESSOR: I must say I do find this difficult. I understand the arguments of both sides. I can see the advantage to the defence, as it were, to have the chance to cross-examine this lady. I would really like a few minutes to think about this because I am finding it a little difficult. The only other question I was going to ask was this. We have been provided with the Foster Report, which is very full and comprehensive but it was written in 1971, which is quite a long time ago. Do the General Medical Council accept that the aims of the Church of Scientology as described in that report are those that they have today?

MR PEARCE: I have no case on that, sir, one way or the other. I noted that it was a non-judgmental report; it made recommendations but did not make judgments. In the large part, it does not make judgments about the Church, though quotes at very great length the Foster Report which certainly did make a judgment on the Church of Scientology. But no, sir, I am not in a position to accept anything – nor, if I may say so, do I think I could ever be. It is not a question of not having enough time. I do not think we could ever be in a position in which we would want to take a stance in respect of an organisation such as this. I cannot imagine so.

THE LEGAL ASSESSOR: Mr Morris obviously has no objection to the Foster Report going before the Committee, but given it was such a long time ago are you saying that nothing has changed since 1971?

MR MORRIS: Sir, I am. I can present to the Committee some newspaper coverage of actions taken by the Citizens’ Commission on Human Rights that postdate 1971, but I thought out of fairness I ought to show those to my learned friend before I submit them to the Committee. My instructions are that the attitude of the Church and the Commission in particular has not changed.

THE LEGAL ASSESSOR: Thank you. I would like a moment to think about this because I am finding this difficult.

THE CHAIRMAN: We will adjourn until roughly 3.30.

THE LEGAL ASSESSOR: Thank you.

(The Committee adjourned for a short time)

THE CHAIRMAN: I will turn to the Legal Assessor to give his advice before the Committee go into camera.

THE LEGAL ASSESSOR: Mr Chairman, I am most grateful for the time I have been given to think about this. As I have indicated, I have found it quite difficult.

Mr Morris wishes to make an application to stay these proceedings and, as I understand
it, he wishes to have the opportunity to cross-examine Master D’s mother with a view to eliciting evidence that would support his contention that these proceedings are an abuse of the process.

The burden is upon the practitioner to prove that these proceedings are such an abuse. However, as I understand it, on this occasion Mr Pearce, for the GMC, concedes that if D’s mother can assist he is willing to call that witness so that Mr Morris may elicit evidence in support of his application. The question, therefore, is can D’s mother provide any relevant and probative evidence that would assist in advancing Mr Morris’s submission?

On the face of it, the most that can be achieved is that the information she provided to the General Medical Council is false and that this of itself would fall short of evidence of oppressive behaviour or otherwise bad faith by the General Medical Council in prosecuting these proceedings. However, given the width of the category of conduct which can be described as being abusive, coupled with and, in my view, the very fair attitude of counsel for the GMC and – perhaps this is the important part – the uncertainty of what may be elicited in the cross-examination of D’s mother, my advice on the particular facts of this case is that Mr Morris should have the opportunity to cross-examine that particular witness.

That is my advice. As you are aware, of course, it is only advice, but that is, in my view the fair way to proceed under Article 6 of the European Convention of Human Rights as incorporated into our law, which requires that the practitioner has a fair trial. I have taken into account the authorities as to what conduct and circumstances may render a prosecution an abuse, which are set out at paragraph 4/56 of the 2003 edition of Archbold’s Criminal Pleadings, Evidence and Practice.

It will be obvious to you all that I have read from a prepared note. I hope I have made my reasoning clear on the facts of this particular case.

THE CHAIRMAN: Did you wish to come back on anything the Legal Assessor said, Mr Pearce?

MR PEARCE: No, sir.

THE CHAIRMAN: Mr Morris?

MR MORRIS: No.

THE CHAIRMAN: At this point, the Committee will go into camera and strangers will withdraw.

STRANGERS THEN, BY DIRECTION FROM THE CHAIR, WITHDREW AND THE COMMITTEE DELIBERATED IN CAMERA

STRANGERS HAVING BEEN READMITTED

THE CHAIRMAN: Mr Morris, the panel has considered your request and has agreed that
we can have an adjournment to allow time for you to bring the handwriting expert and to allow you to cross-examine or examine Master D’s mother. The question I have to put to you is when do you want that to be? I know that Mrs D cannot be here before Wednesday morning. I do not know if you want to do anything tomorrow with the handwriting expert, or do you want to do everything on Wednesday morning? There may be minimal advantage in having the handwriting expert tomorrow, but I thought I would make that over to you.

MR MORRIS: It would obviously help in terms of timing, but the thought occurs to me that it might be helpful for the expert, as she will be an expert, to hear what the lay witness has to say.

MR PEARCE: I must say it strikes me that, if Mrs D has an explanation, the expert will need to know what it is. I could not put to the expert a purported explanation, because I do not know what, if any, explanation there might be. I also suspect the handwriting expert evidence would not be long in any event.

THE CHAIRMAN: We will go ahead at 9.30 on Wednesday morning, so there will be no hearing tomorrow.

MR PEARCE: Would the Committee consider sitting at nine o’clock on Wednesday? I suggest it only to try and maximise the available time. Perhaps it does cause inconvenience.

THE CHAIRMAN: It certainly does not cause inconvenience at this end of the table. I do not think it causes inconvenience round the table. We have always got to be mindful we do not go on too long, otherwise we could be subject to criticism. Nine o’clock on Wednesday morning.

(The Committee adjourned until Wednesday, 21 January at 9 a.m.)
GENERAL MEDICAL COUNCIL

PROFESSIONAL CONDUCT COMMITTEE

On:
Wednesday, 21 January 2004

Held at:
Barnett House
53 Fountain Street
Manchester M2 2AN

Case of:

PATRICK VERNON FINN COSGROVE MB BS 1968 Lond
(Day Two)

Committee Members:
Professor N Mackay (Chairman)
Dr A Hamilton
Mr J Matharu
Dr B Stanley
Mr R Briden (Legal Assessor)

MR D MORRIS, of Counsel, instructed by Messrs RadcliffesLeBrasseur, appeared on behalf of Dr Cosgrove, who was present.

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

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

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THE CHAIRMAN: Good morning. We have a little bit of ordering to put into place in that one of the witnesses who, technically in the body of the hearing would have been a GMC witness, but really is attending at the request of Mr Morris.

MR PEARCE: Sir, may I explain the position here? The witness who I propose to call to tender to Mr Morris to cross-examine is, to the best of our knowledge, in a cab somewhere in Manchester on her way here. We are expecting her arrival at any moment.

I know that the handwriting examiner who we referred to on Monday is in the building and my learned friend, understandably, wishes to speak to her briefly before the evidence starts. There are certain documents, it became apparent yesterday, we do not have copies of but I think my learned friend does, so he is going to provide us with copies of those.

If I may add all of that together, the best laid plans of mice and men often go awry and I should not have suggested nine o’clock.

THE CHAIRMAN: That is a very appropriate quotation for Burns week!

MR PEARCE: If I suggested we started at 9.30 perhaps we would not have been ready until 10 o’clock, whereas this way what I propose to you – I think my learned friend is in agreement – I propose to invite you, subject to there being any hiccups, to retire now and reconvene at 9.30.

THE CHAIRMAN: Mr Morris?

MR MORRIS: I entirely support that.

THE CHAIRMAN: We agree to that, so we will troop out again.

(The Committee adjourned for a short time)

DR COSGROVE: May I make a brief point? I understand very few people can hear Mr Pearce at the back and this is a public inquiry. Could you ask him to hold his microphone up to his face as he speaks?

MR PEARCE: I shall try to speak louder, sir.

THE CHAIRMAN: Mr Pearce.

MR PEARCE: Sir, I think we have reached the stage now where I shall call the witness to whom reference has been made.

May I make one point, sir? It will be apparent to the Committee and those members of the public who have heard the charges being read that throughout patients have been anonymised by the use of letters for their names. In the case of the patient and the patient’s mother, whom I am now going to call for the purpose of this part of the case, it seems to me that it will almost certainly be the case that we will have to refer, before the Committee, to at the very least the full name of the patient’s mother and, realistically speaking, it is probably unlikely that the full name of the patient will not also be referred
to.

It seems to us that at this stage the Committee has three choices: it might consider whether it ought to sit in camera in order to protect anonymity; it might do nothing and allow such reporting as may be considered appropriate, or it might invite those members of the press who are present or who are represented here in any way, shape or form to respect the anonymity of the patient and the patient’s mother. So we do not invite you to go into camera. It seems to us in this particular case and in these circumstances the interests of fairness and of all involved are best dealt with by you taking the third course of action to which I have made reference. Therefore, on behalf of the Council, I invite the Committee to consider taking that action in order, as I say, to seek to protect anonymity if that can be done.

THE CHAIRMAN: I had anticipated that the witness would be referred to as Mrs D and she would identify herself by writing her name on a slip of paper and passing it to both legal teams and to members of the panel. It can occur on occasions that a name could slip out and I certainly would ask, if we do decide to continue in public as you suggest – I am looking round members of the Panel; I think we have got their agreement for that – I would ask members of the press and the public to respect anonymity and confidentiality if, by mistake, her name slips out.

Mr Morris?

MR MORRIS: Sir, I entirely agree that we should make an effort to anonymise and invite the press to resist that and anonymity should be kept.

MR PEARCE: I am obliged, sir. With that, I call the witness, Mrs D. I should say that I propose simply to ask Mrs D to write down her name and address for the assistance of the Committee and that thereafter I will tender Mrs D to my learned friend for cross-examination.

THE CHAIRMAN: Would it be appropriate for her to sign the paper as well?

MR PEARCE: Why not?

MRS D, sworn

THE CHAIRMAN: Good morning, Mrs D. We are referring to you as Mrs D because we wish to protect patient confidentiality and anonymity, so we shall try to refer to that protocol during the hearing. We are not taking all of your evidence at the present time but we will be asking some questions of you.

Examined by MR PEARCE

Q If I might add, Mrs D, to what has been said, that we propose to refer to your son as D. Can I invite you, Mrs D, to write on the paper to your right your name and address and to sign that document for the benefit of the Committee?

(The witness wrote on a piece of paper, which was handed to counsel and the Committee)
THE CHAIRMAN: Just for clarification purposes, you have got your name. Is your name your signature? Do you see what I am getting at? That is the way you would normally sign your name, is it?
A Yes.

MR PEARCE: As I said a moment ago, I tender Mrs D to my learned friend for cross-examination.

Cross-examined by MR MORRIS

Q Mrs D, I would like you to look at some documents, please, and first of all I would ask you to look at a document called D2 and also, I think, D1. Before I ask you any questions, I want to add some further documents to those two sets of documents you have there. (Same handed)

THE CHAIRMAN: This bundle will be D4.

MR MORRIS: First of all, could you look at D1, which has handwriting on?
A Yes.

Q You will see there three letters in handwriting and the top one in my copy is dated September 23, 1996 addressed to Dr Cosgrove with a signature over the page. Is that your signature?
A Yes.

Q Did you write that letter?
A Yes.

Q Turning on, and in fact going back in time to Monday, 27 May 1996, again a letter to Dr Cosgrove with what has your name at the top and a signature at the bottom. Is that your signature?
A Yes.

Q And did you write the rest of that letter?
A Yes.

Q Finally the first letter in time, 26 April, again to Dr Cosgrove, with your name at the top in capital letters?
A Yes.

Q And a signature at the bottom?
A Yes.

Q Is that your signature?
A Yes.

Q Did you write the rest of the body of that letter?
A Yes.
Q I want you to look, please, at D2, which is a typewritten letter to the General Medical Council dated 18 August 2000 and at the top it has typed a name. Is that your properly spelt name?
A Some people spell it with a “p”, some people do not spell it with a “p”. It has got to the point with me spelling my surname now that either it is with the “p” or without the “p”. If it happens to be written with a “p” in it, I will sign my signature with a “p”; if not, I will sign my signature without the “p”.

Q As far as you are concerned, how do you sign your name, with a “p” or without a “p”?
A Without a “p”.

Q Did you type that letter?
A A friend did it on a computer. I wrote the letter and a friend put it through the computer for me.

Q Who was the friend who wrote the letter for you?
A A neighbour of mine just across the back from me.

Q Can you give us her name or his name?
A Why? Why should I involve someone else who is not present here to defend themselves? Can I ask you that?

Q You can ask the question. I can’t answer it. I seek the permission of the Committee to have the question put and the question answered.

MR PEARCE: At least in the first instance I would invite you to ask the witness to write the name down rather than give the name orally, and if you need to consider whether it needs to be given openly you can no doubt do so when you see where this line of questioning is going.

THE CHAIRMAN: Mrs D, would you like to write the friend’s name on a piece of paper?

(Witness wrote the name down. Same handed to Mr Morris, Mr Pearce and the Chairman)

THE CHAIRMAN: Mr Morris have you seen the name? Do you wish to pursue your line of questioning as to revealing the identity?

MR MORRIS: I would like to have the friend’s address written down as well.

THE CHAIRMAN: Would you be prepared to do that Mrs D?
A No I am not. I am not obliged to do that. That is a friend of mine who did a letter for me as a favour, and why should she be brought into this if she is not here? If you can give me a reasonable answer to that question then go ahead.

MR MORRIS: I would like to know how close to this witness the friend lives.
THE CHAIRMAN: Would you like to phrase the question along that line?

MR MORRIS: Mrs D, is this a neighbour or someone from outside Glasgow?
A It is a neighbour.

Q How close in terms of being a neighbour?
A Ten minutes’ distance from me.

Q If I could continue with the documentation, when you are given a letter like that to sign which you say was typed by a neighbour friend of yours, you see that your name has been spelt incorrectly.
A Yes.

Q Do you seek to correct it?
A Not all the time.

Q How well did this neighbour know you before she typed the letter for you? How long had she known you?
A She has known me for about six years.

Q Did she know your name and how it was spelt?
A It is a question that has never arisen.

Q Were you with her when she typed the letter?
A No.

Q How did she know what to write?
A Because I had pre-written it for her and then she put it on to the computer for me.

Q You had pre-written it?
A Yes.

Q How had you spelt your name on the pre-written piece of paper?
A Without a “p”.

Q And was it exactly in this form that we see on the document?
A Yes.

Q So at the top of the handwritten letter that you had drafted there was your name spelt without the “p”, your address.
A Yes.

Q The address to which it was going and everything else that we see in this letter?
A Yes.

Q And at the bottom had you written your name?
A I signed that yes.
A
Q No I am talking about the handwritten draft.
A Yes it was handwritten yes.

Q And at the bottom you had put your name in handwriting.
A Yes.

B
Q And again was that spelt without a “p”?
A Yes.

Q Did you find it strange that despite the fact that you had written a handwritten letter for her to transcribe, she mistakenly transcribed your name?
A No because it is very common.

Q Even when the proper name is written out and available to the person transcribing it?
A Yes. I have various documentation with me spelling the name with an “m” and with a “p” and the Human Resources manager who filled in my expenses claim has spelt my surname with a “p”. My contract of appointment is spelt without a “p”. My Human Resources manager knows me very well. You can look at the pieces of paper that I have brought down.

D
Q Did you sign that letter in anyone’s presence?
A No.

Q Can you look please at D4 now?
A Yes.

E
Q And first in time a letter dated the 21st of June 2001.
A Yes.

Q It is the second page of D4. This is a letter again to the General Medical Council with your name properly spelt at the top, and at the bottom - again this is a printed typed letter - typed with the correct spelling and there is the signature there.
A Yes.

F
Q Is that your signature?
A Yes.

Q You put it there did you?
A Yes.

G
Q Who typed this letter?
A Mr Brian Daniels.

Q Mr Brian Daniels, is he as you describe him of the Citizens Commission on Human Rights?
A Yes.

H
Q Is he the executive director of that organisation?
A I couldn’t tell you. I have no idea.

Q It reads as follows, doesn’t it?

“Mr Brian Daniels, Assistant Commissioner on Human Rights, has contacted me after speaking with you on Tuesday morning. He has informed me that the procurement of my son’s medical records may have been delayed due to a possible confusion over names.”

THE CHAIRMAN: Careful with the names.

MR MORRIS: Thank you sir.

C "In reviewing my previous letter to the General Medical Council I have spelt my surname with a “p” as opposed to without a “p”. This may have caused some confusion for Dr Cosgrove, so I felt that I should write to provide you with evidence to confirm the correct spelling. I enclose a copy of my driving licence for proof of my surname. I hope this will resolve any misunderstanding.”

So there is no issue is there that the correct spelling of your name is without a “p” and that to spell it otherwise is incorrect?

A Yes. My son’s surname has never been spelt wrongly, and I rather think the case is about him and not my surname, is it not?

Q If you look at D2, your son’s surname has been spelt incorrectly hasn’t it?

A Right enough that one has yes.

Q So please be careful before making assertions.

A I am not making assertions. I am just wondering where this is going. I am wondering where this line of questioning is going with the “p” and without the “p”.

Q I am afraid it is not for you to wonder but just to ask the questions and if I am going in the wrong direction I will be told. All right? Just going back to that letter of the 18th of August, whose idea was it to give written consent to facilitate the disclosure of your son’s medical records?

A Could you explain the question as in whose idea was it?

Q You say you wrote a letter in handwriting along these lines. What prompted that?

A The Overload Network in Edinburgh.

THE CHAIRMAN: I am sorry, we cannot hear at this end. Could you perhaps pull the microphone towards you and if the microphone would maybe be a little towards your left because you tend to turn your head towards Mr Morris. That is fine thank you. Would you like to repeat the question Mr Morris?

MR MORRIS: My question was who invited her to draft this letter. I think her answer was the Overload Network in Edinburgh.

A That is correct.
Q Are you sure somebody at the Overload Network in Edinburgh did not draft this letter for you to sign?
A No, positive.

Q I want you to tell us please about the Overload Network in Edinburgh and I hope I might be able to help you. This letter, giving consent for disclosure of records, we know is dated the 18th August 2000. Am I right in saying that as is shown in D1 you say you had been, in that letter, the hand-written letter is 1996, it is clear that your son had been having treatment under Dr Cosgrove’s care, is that correct?
A That is correct.

Q And he had been prescribed two drugs, Ritalin and what you describe as Risperdal in the letter of the 23rd September?
A That is correct.

Q And you say in that letter:

“I am writing to you to apologise for the delay in sending your fee. I have recently moved house and changed my doctor and things are a bit hectic at the moment. D is doing very well with both drugs, Ritalin and Risperdal. My new doctor, whose name and address is Dr Spence in Glasgow is very helpful and has no objection to prescribing the drugs. Not on the telephone, but would hope to be in the near future. I wish again to thank you so very much for your help. If it had not been for you, I think [D] would probably be …” - sorry, I do apologise – “D would probably be in care. I do not want to break contact with you and I will send your money as soon as possible”.

And then you give an old address and a new address:

“Thank you so very much and I hope to be able to speak to you soon”.

Is it right that after that and after you moved to your new address you did not have any further contact with Dr Cosgrove?
A That is right.

Q But your son remained under the care of Dr Spence?
A Yes.

Q And he continued prescribing Ritalin and Risperdal?
A Yes.

Q And that continued until 1999?
A Yes.

Q And then in 1999 did you come to hear about the organisation called Overload in Edinburgh?
A Yes.

Q Was that an organisation that in your view, and according to what they told you,
took another approach to the treatment of Attention Deficit Hyperactivity Disorder?
A Yes.

Q Is that the condition that your son was suffering from?
A That is what Dr Cosgrove diagnosed him as having.

Q And was that a condition that Dr Spence also continued to treat your son for?
A Dr Spence continued to treat [D] on the grounds that Dr Cosgrove was the expert. Dr Spence was by no means an expert in ADHD and took advice from Dr Cosgrove.

Q Who did you speak with at Overload Network?
A Janice Hill.

Q And what did you discover about the organisation Overload Network from Janice Hill please?
A I initially had read a story that Janice had published in the Evening Times in Glasgow regarding Ritalin and the availability of it on the streets for young kids to get hold of and I read her story about her daughter who was roughly the same age as [D] undergoing similar problems and once I had read her story I decided to contact Janice to see what offer of help that she could give me rather than medicate my son, which by this point his behaviour was starting to deteriorate and Janice had suggested instead of putting chemicals into my son’s body to try vitamin tablets, such as the fish oils, vitamin B complex, a range of various multivitamins.

Q And as a result of seeing her did you take your son to see Professor Steven Baldwin?
A That’s correct.

Q Was he a professor in psychology at the School of Social Psychology at Teeside University, Middlesbrough?
A Yes.

Q I wonder if some documentation could be shown to you please? (Same handed)

THE CHAIRMAN: This will be D5.

MR MORRIS: (To the witness) Mrs D, let me just, so there is no mystery about this, these are letters that have been extracted from your general practitioner records, the records kept by your general practitioner, who at the time was Dr Spence, all right?
A Yes.

Q And, I think, actually chronologically we start at the back of the document, which is a letter of referral from Dr Spence to Professor Baldwin; do you see that?
A Yes.

Q Where he tells the Professor that over the last few years we have been treating D as having ADHD and he sets out the problems that your son had had and the fact that he had been on Ritalin mixed with Risperidone, which I think is another name for Risperdal on the instructions of Dr Cosgrove of Bristol and that had been stopped, various other
things had been tried and at the time he was on no medication. Was that decision to stop the Ritalin a decision taken by your son or by Dr Spence, can you recall?

A By myself.

Q By yourself?

A Yes.

Q And then, just running through the documents, on the 3rd February ---

THE CHAIRMAN: The middle part of this page and the next page has not come out very well on the photocopy?

MR MORRIS: It has not, sir, you are right, and we do not have the originals. I do not know whether the Council have the originals; I do not think the originals are available, but it perhaps need not trouble you too much, but it is a request to the practice manager at Gilbertfield Medical Centre, which is where Dr Spence practises, or used to practise, seeking information ---

MR PEARCE: I am terribly sorry to interrupt. We do think we have the originals, we are just seeking them out.

MR MORRIS: … seeking information as to where to send invoice for the consultation with the Professor.

(To the witness) That letter appears actually to have been copied in the records, the next document at page 62 and then at page 61, the 11th February, Dr Spence writing back a response:

“With regard to your letter of the 3rd February regarding D and an assessment carried out by Professor Baldwin. First of all, I never requested this assessment, I think it was organised by his mother through some organisation in Edinburgh. We have never received an invoice for any form of patient care from a University. Presumably if this is the routine event, then you will know that it may have to be sent to Greater Glasgow Health Board. Otherwise this letter just leaves me confused”.

That organisation, is that the organisation Overload?

A Yes.

Q. And then, finally, 29th February 2000, a letter from Dr Spence to Overload Network for the attention of Janice Hill:

“Mrs D attended you with D and subsequent to this she asked me to write a referral letter to Professor Steven Baldwin at your request as a matter of courtesy. As a result of this, I have received a bill from Professor Baldwin, which is obviously something general practitioners in Glasgow are very unused to, but Professor Baldwin seemed extremely surprised at my reaction, particularly as I had written a referral letter”.
Having seen Professor Baldwin with your son and spoken with Janice Hill, how did you come to make contact or be in contact with Brian Daniels of the Citizens Commission on Human Rights?
A Janice Hill forwarded my letter to Brian Daniels.

THE CHAIRMAN: (To the witness) I am sorry, we are having trouble hearing you?
A Sorry. Janice Hill from Edinburgh forwarded … asked, was quite concerned about the drugs that [D] was prescribed by Dr Cosgrove and was concerned enough to inform Brian Daniels from the Citizens of the Human Rights, who in turn contacted myself.

MR MORRIS: (To the witness) And what did you learn from Mr Daniels when he contacted you?
A Could you explain that further; in what way?
Q Yes. He contacted you?
A Yes.
Q What did he say to you, did he write to you or did he telephone you?
A He wrote to me.

Q Do you have the correspondence?
A Not with me I do not.
Q What did he say in his letter?
A That he had been contacted by the Overload Network in Edinburgh and was concerned by the issues raised by Janice Hill in accordance with [D] and the medication he had been given by Dr Cosgrove and I cannot remember exact word for word what actually Brian had written in the letter, but basically from that point on I started correspondence with Brian, because I was concerned when I found out more about the drug Risperidone and the effects that it can have on children and decided to take the matter further and Brian was the one that helped me get to this point.

Q Did he tell you that the Commission of which he was the director had been established by the Church of Scientology?
A Yes.
Q To investigate and expose psychiatric violations of human rights?
A Yes.

Q And after that first letter to you, you say you got into correspondence with him?
A Yes.
Q Tell us, please, the gist of the correspondence and how matters developed with the Commission?
A Matters developed in a way that I should say Brian was the Scientologist – I am not a Scientologist, I am a Roman Catholic and I have been baptised and made my holy communion and married in the chapel. I have nothing whatsoever to do with the Scientology. I was concerned, however, about finding out more, as I said before, about
the drug treatment that Dr Cosgrove undergoes, the way he sends private prescriptions through the post and does not inform the patient of what the drug is about; any of the side effects regarding the drug. So my main concern was, in line with Brian, to stop this man from doing this any more. So Brian and I corresponded with each other simply to do with the drugs that [D] had been prescribed, on my own initiative.

Q Did it come to the stage where he made a complaint to the General Medical Council about an aspect of Dr Cosgrove’s care of your son, D?
A Yes.

Q Did he tell you anything about other complaints against Dr Cosgrove?
A No. Overload told me about other complaints. Overload had a child in Edinburgh. I do not know the person.

Q Overload had a child in Edinburgh?
A Yes.

Q Who had been under the care of Dr Cosgrove?
A As far as I am aware.

Q They told you about that?
A Yes.

Q The complaint that was forwarded to the General Medical Council by Brian Daniels, did you authorise the sending of that complaint?
A Yes, I did.

Q As part of the authorisation of that complaint you told us that you signed the letter that we see in D2 on 18 August 2000, is that right?
A Yes.

Q Are you sure that that is your handwriting and the signature there?
A I am positive that is my handwriting.

Q If that is your handwriting, Mrs D, are you sure that the letters we see at D1 are your letters, written and signed by you, the 1996 letters?
A Yes.

Q I suggest that those letters in 1996 were signed by somebody different from the person who signed the letter on 18 August 2000?
A You can suggest what you want, but I signed all the letters that are in front of me.

Q Again looking at D4, the signature on 11 December 2001 letter and the 31 June 2001 letter, again I would suggest that those signatures were not written by the same person as wrote the letters and signed the letters in 1996?
A As I said before, you can suggest what you want. If you want me to write the signatures now, in front of the people sitting here, I will do that.

Q You have given a signature just now?
A I will give you a signature to the one I have written in 1996 if you like, if that is where the confusion is coming from.

Q We may come to that, but leave it for the moment. Again, just to make my position absolutely clear, the letter of 21 June enclosed a copy driving licence?
A Yes.

B Q That has got a signature on it. Is that your signature?
A What copy is that?

Q It is the back page, last page of the bundle D4. It is attached to the letter of 21 June 2001?
A Yes, that is my signature.

C Q Do you have that driving licence available?
A Unfortunately, I do not, no. The driving licence was destroyed.

Q Why was the driving licence destroyed?
A It was torn up by mistake, along with some other documentation. It was not in its proper folder, it was in amongst some documentation I was throwing out, so the driving licence was initially torn up. That has never, ever been replaced again because initially I had the old-fashioned driver’s licence, which was the paper one; the new one, as you know, is a card where you have a photograph taken. I do not have a car at the moment so I do not need a driver’s licence, so I have not gone to the bother of getting a picture taken and applying for a driver’s licence.

Q Again, I suggest that whoever wrote that signature is not the same person who wrote the 1996 correspondence?
A You can suggest what you want.

Q So can you help us, please, with what your understanding of Overload’s attitude to Dr Cosgrove was? I think you said it was their intention to stop him treating him this way?
A Did I say that?

F Q I do not know; I may be incorrect. What is your understanding of what Overload’s ambitions were in relation to Dr Cosgrove?
A Initially to Dr Cosgrove but not just Dr Cosgrove, to any doctors or psychiatrists out there who think they can medicate children and give them mind-altering drugs, and especially drugs that are not licensed for the specific ADHD as [D] was diagnosed by Dr Cosgrove.

G Q What was their plan in order to prevent this as far as Dr Cosgrove was concerned?
A To follow complaints by people that came forward to them that we were not happy with Dr Cosgrove’s treatment or follow-up treatment.

Q What about the Citizens Commission for Human Rights?
A What about them?
Q You had correspondence with Mr Daniels, did you not?
A Yes.

Q Did you meet him?
A No.

Q Did you speak to him?
A I have spoken to Brian, yes.

Q When did you first speak with Brian?
A When I initially went to Overload, which was four years ago.

Q And when you spoke to him there was he present?
A No. How could he be present if I have not met him?

Q Did you speak to him on the telephone?
A Yes.

Q Was that at Overload’s offices?
A No, it was my home.

Q Did he telephone you?
A Yes, he telephoned me after Janice Hill had said she was going to write to Brian and would I mind forwarding my home telephone number in order that he would be able to contact me and I said “Yes”.

Q What were Brian’s plans for Dr Cosgrove?
A Brian was of the same opinion as myself, that Dr Cosgrove was giving out medicines to children, quite flippantly, to be honest with you. What doctor sends a prescription through the post, a private prescription through the post to a patient who he has seen for 25 minutes and has offices down at Bristol, and gives you a second line drug over the telephone, not telling you what the drug is, only to tell you on the telephone that this second line drug will be introduced to take away any of the side effects that the first line drug, which was methylphenidate, commonly known as Ritalin, given to [D], this will take away [D]’s not being able to eat, not being able to sleep; not giving me any information at all about the drug, not telling me it was a drug for manic depressives or schizophrenics, not telling me it was a drug that was not licensed for children under 16 – and [D] was 10 years old at this point – and this was sent through the post to me.

Q That information that you have just given us, where did you get all that from?
A I can read.

Q Where did you read it?
A I had various papers that Overload had regarding the drug.

Q So this was documentation that came from Overload?
A Yes.

Q So what did you understand Brian Daniels was proposing to do about
Dr Cosgrove?
A Expose his treatment of over-medicating young children.

Q And how was he going to do that?
A Specifically write to the GMC.

Q So he was going to write to the GMC not only in relation to your child but in relation to other children?
A I cannot answer for other children.

Q Is that your understanding?
A I can only speak for myself, but I have no knowledge of other children Brian was acting for.

Q I know you have no knowledge yourself, but was it your understanding (I think you said) that Brian Daniels was going to write to the GMC about your child and other children?
A Did I say other children?

Q I think you did. I will be corrected if I am wrong.
A I do not know if I said other children – I did not. I said my son.

MR MORRIS: I do not want to take a bad point....

THE CHAIRMAN: What I noted down was his intention was to expose Dr Cosgrove’s prescribing and over-medicating of young children.

MR MORRIS: Thank you.

MR PEARCE: My note closely agrees with yours.

MR MORRIS: That is what is recorded that you said, Mrs D, that it was Brian Daniels’ plan to expose the over-medication of young children. Was that right?
A Yes, I would say so.

Q Can I just ask you again to write down on a piece of paper, please, Mrs Daniels, the full name of D’s father?

(The witness wrote on a piece of paper, which was handed to counsel and the Committee)

MR MORRIS: Just some more information I would like you to write down on a piece of paper. I think in the correspondence. Actually it may not be necessary. No it will not be necessary. Can I ask you this, has D your son had German measles?
A Yes.

Q Has he suffered any broken bones?
A Yes.

Q Can you tell us which?
A He had broken his wrist a few times. He has been at the hospital with staped ankles.

Q With what ankles?
A He has staped his ankles when he has fallen off things.

Q You used a word that as I don’t come from Glasgow I didn’t understand about your son’s ankle.
A Yes.

Q Staped?
A Yes.

Q What does that mean? The Chairman is looking extremely knowing and I am in ignorance. It may be that some of the Committee, certainly not all of the Committee ---

THE CHAIRMAN: Another term would be he had sprained his ankles.

MR MORRIS: Did he ever suffer a fracture of any bones in his ankle?
A Yes he did.

Q Can you just help us with this please, first of all where did you visit him?
A Down in the Bristol Priory clinic.

THE CHAIRMAN: Could I check that it is the Priory clinic and not the Priority clinic? We raised this at the beginning. It is Priority.
A Well Priority. I know it was like a surgery. I think Dr Cosgrove had one room in this. It was a Health Centre. Dr Cosgrove had a room in the Health Centre because there was a reception desk and I don’t know whether Dr Cosgrove rented the room privately or not because there were other doctors and patients coming into the room, coming into the Health Centre.

MR MORRIS: Can you remember the address of it?
A No I can’t, not off hand.

Q You have described it as a Health Centre.
A Yes, that is what I would say it was.

Q In which town did you visit Dr Cosgrove?
A Bristol.

Q Are you sure it was Bristol?
A Yes I am sure it was Bristol.

MR MORRIS: Yes, thank you.

MR PEARCE: Sir, before I ask questions of this witness by way of re-examination, I seek if I may through you some clarification for the purposes of this stage of where we are with the proceedings. A lot is being put to this witness. It is quite clearly being put
that there are issues about the signature, and I accept that that is clearly put, but on
Monday my learned friend repeatedly used the expression that this charge was a fraud,
and what I took him to mean by that – maybe I am incorrect – was that either the person
who I was going to call today, the person whom I have called today, was not truly the
mother of the person who had been treated by Dr Cosgrove, and so it was fraudulent in
that sense, or in the alternative that if she was the mother of the person who had been
treated by Dr Cosgrove, she in fact had no complaint whatsoever against Dr Cosgrove but
had been put up, for want of a better expression, to complaining by a third party, and
clearly it seemed to me to be being suggested that that was at the commission of Mr Brian
Daniels. If either of those two or some other interpretation of what a fraud may mean is
part of my learned friend’s case as part of his submission on abuse, then his case in
respect of that fraud should in my submission be put to this witness so that I know the
factual arguments I must meet, and if I may so sir so that you do sir too know what
actually is being said about this witness, this complaint. Of course I don’t ask him to put
his wider submission on the point but on the specific factual matters in so far as the
allegation that this is a fraud is being pursued, what does that mean factually, those points
should in my submission be put to this witness now.

THE CHAIRMAN: Mr Morris?

MR MORRIS: I quite understand the request, and before I make the position absolutely
crystal clear I would like to take some instructions from Dr Cosgrove who has listened to
the evidence, if I could be permitted to do that.

THE CHAIRMAN: You want a break just now?


THE CHAIRMAN: We will have a break and re-convene at 11.15. Mrs D, could I
remind you that during the break you remain under oath and you mustn’t discuss your
evidence with anyone.
A: Sure.

(The Committee adjourned for a short time)

MR MORRIS: Sir, before I put the case that my learned friend invited me to put, quite
understandably, to the witness I do need to show her and ask her about two further
documents. I am afraid they are being photocopied at this very moment but they should
be with us shortly. Could I ask for the indulgence of the Committee while that takes
place? Sir I am grateful for the time you have given me. Mrs D, I want you to have a
look at two documents to begin with if I can have them. (Same handed)

THE CHAIRMAN: This one dated the 18th of August 2000 would be D6. This one
dated 31st October 2000 will be D7. (Same handed)

MR MORRIS: (To the witness) Mrs D, I think if we look at D6 please. This is a letter
which has the same date, 18th August, as the letter in D2, which is the letter you say you
signed and was typed by a friend of yours – a neighbour – on the 18th August 2000. D6
is again a letter to the General Medical Council with your name wrongly spelt at the top
and on the second page there is your name in type wrongly spelt at the base of the letter and there is no signature. What can you tell us about that document, have you ever seen it before?
A  Yes.

Q  When did you see it first?
A  I wrote the letter first. I had written in my handwriting.

Q  You had written it in your handwriting?
A  Mm.

Q  Do you still have the hand-written letter anywhere?
A  No.

Q  Who typed it?
A  Brian Daniels.

Q  Brian Daniels typed that, but he did not type the letter we see in D2 of the same date?
A  No.

Q  When did you first see the typed version of that letter?
A  To be honest I can’t remember.

Q  I suggest you certainly did not see it before it was sent to the General Medical Council, did you?
A  I suggest you are wrong.

Q  Because I suggest if you had seen it you would have signed it?
A  I suggest you are wrong.

Q  Why did you not sign it if you saw it before it was sent to the General Medical Council?
A  Probably because it was typed out.

Q  Because it was typed out you did not think there was any need to sign it?
A  No.

Q  Why did you sign it?
A  It may have been an oversight.

Q  An oversight?
A  Could have been.

Q  This is a letter of complaint about Dr Cosgrove?
A  That is correct.

Q  To his disciplinary body, is it not Mrs D?
A  That is correct.
Q And you think it was an oversight that you did not sign it?
A Yes.

Q Before it was sent?
A Yes.

Q I suggest you never saw it before it was sent?
A I suggest you are wrong.

Q Look at D7 please, the letter dated the 31st October, again to the General Medical Council, this time from Brian Daniels?
A Yes.

Q Which says this, and I will not mention names:

“Re D” – spelt incorrectly.

That is right, is it not?
A Excuse me, say that again?

Q Your son’s name is spelt incorrectly?
A Yes, that is correct.

Q “Dr Patrick Cosgrove.

Thank you for your letter of 18th October. I have contacted Mrs D” – spelt incorrectly – “and she has provided me with the following information:

1. D’s date of birth – 12/02/86.

2. The exact date that she took D to see Patrick Cosgrove is not known, but it was in the month of May 1996.

3. The place that she attended with D was the Bristol Priority Clinic in Bath.

4. Here address in September 1996 was …” – an address in Glasgow.

5. The name of her GP in September 1996 was Dr John Spence”.

Q Do you recall speaking to Mr. Daniels and giving him that information?
A Yes.

Q Did you tell him that the place you attended with D was the Bristol Priority Clinic in Bath?
A Yes.

Q And is that what you felt then in October 2000 was the place where you saw Dr Cosgrove?
A

Q Why is it that today you told this Committee that you saw Dr Cosgrove in Bristol?
A It is the Bristol Priority Clinic, so I travelled down to Bristol to see Dr Cosgrove.

B

Q But here in this letter, according to information you say you gave to Brian Daniels, you were telling Brian Daniels that the place you attended for consultation was Bath; can you help us with the disparity?
A Disparity is maybe my geography is not that good. I got a train from Glasgow down to Bristol, stayed overnight in a bed and breakfast and went to the Bristol Priority Clinic. If it is in Bath, sobeit.

Q You know that Bristol and Bath are two completely separate cities, do you not Mrs D?
A Well why is it called the Bristol Priority Clinic if it is in Bath?

D

Q Can you answer my question; you know that Bristol and Bath are two completely different cities?
A Yes, I do, I do.

Q I suggest that the person who gave that information to Brian Daniels was not the mother of D?
A So you are accusing me of not being the mother of D?

E

Q I am.
A Well can I say that you are a liar and I would ---

THE CHAIRMAN: (To the witness) I know that it is difficult for you and it is frustrating, but could you please respond “Yes” or “No”? A Okay. I am Mr D’s mother.

F

MR MORRIS: (To the witness) Because the mother of Mr D would have known very well when giving important information in relation to a complaint being made to this Doctor’s disciplinary body about the place she took her son many, many miles to see Dr Cosgrove ---
A Yes.

G

Q … on only one occasion ---
A That’s right.

Q … was in Bristol and not in Bath?
A I travelled down from Central Station to the Bristol Priority Clinic and went to see Dr Cosgrove the following morning.

H

Q I would like you to look, please, at another document. (Same handed)
THE CHAIRMAN: This will be D8.

MR MORRIS: (To the witness) Mrs D, this is a five page document which is entitled ‘Statement of Mrs D’ and can you look at the last page please? There is a signature there over the typed name of Mrs D; is that your signature?
A Yes.

Q Just have a look, please, at that signature and indeed the signature you wrote on D2 three years earlier on the 18th August 2000, which you say you deliberately signed incorrectly with a ‘p’ in?
A Yes.

Q And then just have a look please at the signatures on the three hand-written letters of 1996 at D1. The 1996 signatures look very different from the signatures of 2000 and 2003, do they not?
A The one in 1996 the first letter is actually printed rather than the signature if you look at it. The other one is a shortened version, the ‘e’ is not signed as in my first name, as in the next letter.

Q So would you agree with my comment that they look very different from the signatures of 2000 and 2003?
A I can see the one in 1996 is printed rather than the signature; the rest of them are the same apart from the ‘p’.

Q So you would not call that a signature as such in 1996?
A No, because as you can see by the handwriting it was a hectic time, I was moving from one place to another and trying to organise, I had lost contact with Dr Cosgrove at that time and I wrote this letter and more or less signed it at the bottom, but not as I would say a proper signature as in a written.

Q I think you were asked yesterday on behalf of the General Medical Council and the solicitors acting for them to bring some hand-written material from that period, 1996 -
A Yes, I was already on the train at that time before I could get information from any of the solicitors, I was travelling down to Glasgow at that point.

Q Are you saying that your signature in 1996 then looked different from what we see on those three letters?
A I am not saying it looked different, I am saying I have signed it differently.

Q Do you accept it is signed differently?
A Yes.

Q If I can just take you to the body of the statement please. In the first page of the statement you give an outline of the history concerning your child D, leading up to the time when we see over the page in paragraphs 8 and 9 you travelled to see Dr Cosgrove; is that correct?
A Yes.
A  And you talk about him being seen at school by the educational psychologist and you talk in paragraph 7 that you heard about the disorder, Attention Deficit Hyperactivity Disorder, on a television programme being discussed by a Mr. Christopher Green and you got in touch with a family support group run by Jill Meads and you explained that your son had been seen by a number of general practitioners who were unable to help with his behaviour and then the suggestion of seeing Dr Patrick Cosgrove?

A  That is correct.

Q  The child D had not only been seen by general practitioners I suggest, but had been seen by a consultant psychiatrist before seeing Dr Cosgrove; do you know about that?

A  Correct.

Q  The child D, shortly before seeing Dr Cosgrove, had spent at least two weeks as an in-patient in a psychiatric ward at the Children’s Hospital?

A  Correct.

Q  None of that information appears in that statement, does it?

A  No.

Q  And I suggest that as the mother of D, the mother of D in making such a statement would have included such information?

A  Why?

Q  In the information; do you accept that or not?

THE CHAIRMAN: (To the witness) Mrs D, could I ask you to answer the questions rather than ask questions?

A  Okay. Could you ask me the question again?

MR MORRIS: (To the witness) Yes. The mother of D in making a statement about the treatment her son had received at the hands of Dr Cosgrove and setting out the history, his medical history prior to seeing Dr Cosgrove, would have included the important information that he had been under a child psychiatrist and indeed an in-patient in a children’s hospital, I am suggesting?

A  I understand where you are coming from, but I did not think that was important in the making of this statement because this statement was about the treatment of Dr Cosgrove, not the treatment of D by the National Health Trust in Glasgow.

Q  In the course of making this complaint about Dr Cosgrove you signed an authority to disclose his notes?

A  Correct.

Q  Have you seen those notes?

A  No.

Q  So do you know to whom the notes were disclosed?

A  The General Medical Council and parties that were to be covered at the hearing.
today, as far as I am aware.

Q Looking at paragraph 10 please? The author of that statement, and you say you are the author of that statement, says that D saw Dr Cosgrove at a hospital in Bristol where he rented a room. That, I suggest, is wholly inaccurate, not a hospital?
A Correct, a hospital or a health centre. ‘Hospital’ may have been the wrong word, possibly ‘health centre’ should have been written down.

Q So it was not a hospital, you agree that?
A Yes.

Q You say that in the statement, which you say is yours, that the consultation lasted between 15 and 20 minutes, is that right?
A That is correct.

Q The mother of D, I would suggest, would have known that the consultation lasted at least an hour and probably an hour and a half?
A The consultation originally was booked for one hour, which the fee for the hour to spend with Dr Cosgrove was £160. Myself and my son saw Dr Cosgrove, we were with him for between 15 to 25 minutes and then we were released with a private prescription in my hand to go to the nearest chemist. Can I just add that Dr Cosgrove made a remark regarding my son saying “They’ve travelled all the way down from Glasgow and this child hasn’t been able to sit down on the train for all the time they’ve been travelling”, and he made a joke about it to another patient who was passing by – “She’s travelled all the way down from Glasgow and this kid hasn’t been able to sit in his seat”.

Q Paragraph 18. The author of this statement says:

“Dr Cosgrove again telephoned me to see how [D] was and I told him the Risperidone appeared to be helping with [D] eating and sleeping. He had become lethargic but I thought that was how he should be on the medication.”

Just to set the picture a little more clear, perhaps I ought to do it chronologically. If I take you back to paragraph 13, at the end of the consultation you stated:

“Dr Cosgrove informed me he would check on [D]’s progress in a fortnight by telephone and his fees for this would be £25.00.

Dr Cosgrove to telephone two weeks after the initial consultation. I informed him that I was still having problems with [D]’s behaviour and he decided to increase the dose of Ritalin. A further two weeks passed and again Dr Cosgrove contacted me by telephone. By this time I was very worried about [D] as he was not eating any food nor was he sleeping and he has lost a lot of weight.

I told Dr Cosgrove of my fears and felt that the medication was not working as well as I had hoped. At this point Dr Cosgrove told me that he was going to prescribe another drug which to the best of my
recollection he did not name but did state that it would help [D] to sleep and eat and would counterbalance the Ritalin and resolve any behaviour problems.”

Then 17:

“Dr Cosgrove sent me a private prescription for Risperidone which I had dispensed at Boots Chemist at the cost of £30.00 for ten tablets. I remember when I took the prescription for dispensing the chemist staff appeared alarmed for what had been prescribed for a ten year old boy.

Dr Cosgrove again telephoned me to see how [D] was and I told him the Risperidone appeared to be helping with [D] eating and sleeping. He had become lethargic but I thought that was how he should be on the medication.

I could not afford to pay Dr Cosgrove for the telephone consultations and I never heard from him again. I was also unable to afford the cost of any further private prescriptions and I went to consult my general practitioner.”

Just looking at that, and if we take you back, please to D1, the second letter in time dated 27 May 1996?

A Okay.

Q If you look at the letter for 27 May:

“[D] started his medication on Friday 24th May. So far so good, the only side effect I can see at the moment is his appetite, which you told us about.

The other thing I need to mention is that my own doctor will not prescribe Ritalin for [D]. What they have said to me is that I have gone outwith the NHS and gone against Yorkhill Hospital, Glasgow and I will have to get my prescriptions from you privately. I would be most grateful if you could advise me what to do as I do not want [D] to run out.”

Then the next letter, September 23:

“I am writing to you to apologise for the delay in sending your fee. I have recently moved house, and changed my doctor so things are a bit hectic at the moment. [D] is doing very well with both drugs, Ritalin and Risperdal. My new doctor who’s name and address is Dr Spence”

- I have read this before.
“I am not on the telephone yet but hope to be in the near future. I wish again to thank you so very much for your help. If it had not been for you I think [D] would probably be in care. I do not want to break contact with you and I will send your money as soon as possible.”

That account, do you agree, is wholly different from the account in the statement you say you signed on 14 July 2003?

A Describe in which way you mean.

Q The person who was the mother who wrote the letters, I suggest, in 1996 was quite happy with the treatment that her son was receiving and felt that but for it her child would be in care by now and that the only concern was the question of appetite. That is totally different, I suggest, from the account that you have given in this document of 2003?

A Do you want me to answer?

Q No mention of sleeping problems, weight loss problems, no mention of lethargy in your correspondence---

A Excuse me, which one are you talking about? Letter D1?

Q D8?

A Which one are you referring to at the moment?

A In D8 you talk about — I will just take you to the paragraph. 14:

“Dr Cosgrove to telephone two weeks after the initial consultation. I informed him that I was still having problems with [D]’s behaviour and he decided to increase the dose of Ritalin. A further two weeks passed and again Dr Cosgrove contacted me by telephone. By this time I was very worried about [D] as he was not eating any food nor was he sleeping and he has lost a lot of weight.

I told Dr Cosgrove of my fears and felt that the medication was not working as well as I had hoped. At this point Dr Cosgrove told me that he was going to prescribe another drug which to the best of my recollection he did not name but did state that it would help [D] to sleep and eat and would counterbalance the Ritalin and resolve any behaviour problems.”

Then 17:

“Dr Cosgrove sent me a private prescription for Risperidone.”

18:

“Dr Cosgrove again telephoned me to see how [D] was and I told him the Risperidone appeared to be helping with [D] eating and sleeping. He had become lethargic but I thought that was how he should be on the medication.”
In the mother’s correspondence in 1996 there is no mention of those problems, the lethargy, the weight loss or the like, was there?
A In D1, no. There is a mention of [D] not being able to eat and not being able to sleep and my concerns about that, and that is why the second line drug was introduced, to combat the side effects of Ritalin.

Q If you could look at paragraph 26 of D8, the statement:

“In September 1996 I received some correspondence from a Doctor Bramble and Dr Cosgrove in relation to a Risperidone survey. I am not sure how I came to receive this correspondence as I had moved from the address I was at when Dr Cosgrove was prescribing to [D] and I did not give Dr Cosgrove a forwarding address.”

Look, please, at D1?
A D1 was written when I received the Risperidone survey through the post. This letter was written in response to the survey that I had received from Dr Cosgrove and Dr Bramble.

Q Just pause there. In your statement you say:

“I am not sure how I came to receive this correspondence [in September 1996] as I had moved from the address I was at when Dr Cosgrove was prescribing to [D] and I did not give Dr Cosgrove a forwarding address.”

A In the letter of 23 September 1996 the mother of D provided a forwarding address?
A That is correct, but the survey came through to me at 90 Finlay Drive before I had written this letter. That is the reason why I do not understand I received the letter, because I had moved from Bemerside Avenue in Mansewood to 90 Finlay Drive in Dennistoun. This letter came in the post addressed to me. Whether it was forwarded on from my previous address I am not sure, but at that point Dr Cosgrove did not have my new address when this letter was written in response to the survey I had received this letter from Dr Cosgrove and Dr Bramble.

Q Dr Cosgrove had the address of 14 Bemerside Avenue back in May?
A That is correct, back in Mansewood.

Q And then in September you wrote from 90 Finlay Drive?
A Correct.

Q Stating your old address---

THE CHAIRMAN: I think we are in danger of breaching confidentiality by this use of addresses.

MR MORRIS: Yes, you are quite right. (To the witness) In the letter of 23 September, if
I can call them address 1, address 2 and address 3, perhaps that would be easier, in chronological order. In May and April you wrote from address 1?

A Yes.

Q In September you wrote from address 2?

A Correct.

Q Setting out there your address 1 and the new address 3 that you were at that time at?

A Correct.

Q So how can you say in your statement that you had not given Dr Cosgrove a forwarding address?

A I did not give Dr Cosgrove a forwarding address when I had moved from address 1, that is when I initially contacted Dr Cosgrove, when I moved from that one address to my new address and I had written this letter, I had not informed Dr Cosgrove at that point that I had moved. It was only when I received the survey from himself and Dr Bramble, a questionnaire-type survey, for myself to fill in to check [D]’s progress on the Risperidone is when I wrote this letter back to confirm my new address, apologies for not informing him beforehand and not paying his fees.

Q Mrs D, what I am suggesting to you is that because what I suggest are the inaccuracies in the statement D8 (14 July), the information provided from you in D7 to Brian Daniels about the place of consultation, the formulation of a complaint by you which is typed with your name spelt incorrectly (D6), that all of those are the actions of someone who was not the person who took D – not the mother of D – to see Dr Cosgrove in 1996?

A Would you like me to respond to that?

Q Please?

A I am telling you I am the mother of [D]. I went to see Dr Cosgrove with [D]---

THE CHAIRMAN: I do not think that was actually the question that Mr Morris put, was it?

A What was the question then? That I am the wrong person?

MR MORRIS: I am suggesting that the person – and you say it is yourself – who wrote and were responsible for the statement of 14 July 2003, the information given to Brian Daniels and repeated in his letter of 31 October 2000 (D7), the letter formulated at D6 and dated 18 August 2000, could not possible have been the person who took D to see Dr Cosgrove in 1996?

A No, that was wrong. I am the person – the person who has written the letters, I am the person who took D to see Dr Cosgrove and I am the mother of that person.

MR MORRIS: Thank you.

MR PEARCE: Sir, for the purpose of my re-examination I am going to invite you for the first part of that re-examination to sit in camera. May I explain why? The application itself can probably be made openly with members of the public present. Sir, I have
before me a large bundle of medical documents which are or at the very least purport to be the medical records of the patient D. Those records contain a large amount of information which the true mother of D, whether it is this lady or somebody else, will know, and in my submission it is appropriate that you hear questioning, non-leading questioning I hasten to add, about D’s medical background in order for you to establish, if necessary by comparison with those medical records, whether indeed in making your decision on the issues that arise, you believe the person before you to be the mother of D.

Sir, those medical records, like anybody’s medical records, contain a large number of private and confidential matters. In this particular case they, if I may say so, contain far more than the average person’s details, very private and personal details, details which if I may say so again without condescending to any of the particularity at all, relate not only to D but also to potentially the mother of D and also potentially to other people. It would be quite inappropriate of me, and I think impossible of me to do the questioning before the Committee openly with members of the press present, even with the assistance, if I may put it that way, of the guidance you have already given from the viewpoint of the Committee, since I am acutely aware of the fact that whatever you have to say about confidentiality there is nothing binding on those members of the press here present, and I take the view frankly sir that I couldn’t take this line of questioning at all unless you were in camera because it would be quite improper for me to start airing personal and private matters in this kind of respect. I invite you to go into camera for that part and that part only of my re-examination.

THE CHAIRMAN: Mr Morris?

MR MORRIS: I would have no objection to that course.

THE CHAIRMAN: The legal assessor wants to speak.

THE LEGAL ASSESSOR: I have nothing to say about the actual application itself. I just wanted to come back to Mr Morris’s cross-examination. I just ask, is it part of your case that this lady who is in court today was not the lady who went to see Dr Cosgrove?

THE CHAIRMAN: I thought we were going to get clarification of that later on when you made your formal submission.

THE LEGAL ASSESSOR: The reason I raise it is because if it is part of your case that this lady did not go and visit Dr Cosgrove, this lady who is in court now, I think that should be put to her.

MR MORRIS: Let me take instructions. (Takes instructions from Dr Cosgrove) Sir I haven’t gone that far and I don’t go that far. I hoped I had made it clear in my questioning to her, and I think it is right I make it at this stage so my learned friend can deal with it rather than in submission at a later stage, what I am saying and suggesting is that the person – I accept it is the mother of D who took her child to see Dr Cosgrove in 1996 – is not the same person who has written but not signed a letter of complaint of the 18th of August 2000, who has signed a consent to disclosure of medical records on the 18th of August 2000, who made and signed the witness statement which you have before me.
you, that person is different from the mother of D. All I am saying and putting to this witness is either she is the mother of D and she is not correct when she tells you that she is also the person who has formulated the complaints and the documentation of 2000 and onwards, or she is the person who has formulated the complaints and material from 2000 onwards, and if she is then she is not the mother. I hope I have made the position clear. Those are the two options.

MR PEARCE: By way of clarification, may I be clear I think it follows from what my learned friend says that his second case includes the fact both that the person present in court is not the mother of D, and also the person present in court did not attend the consultation with Dr Cosgrove in 1996. That is how I understand it to be, the obverse of the first.

MR MORRIS: If the witness is the compiler of the complaints of 2000 onwards, she is not the mother of D who took the child to see Dr Cosgrove in 1996.

THE LEGAL ASSESSOR: This witness has said that she took her child to see Dr Cosgrove in Bristol. Is that evidence challenged or not?

MR MORRIS: I am not sure I can take it any further than what I said. If she is saying that she is the mother and that she took her child to see Dr Cosgrove in 1996, and she is also the person who has formulated the complaint, who has made a witness statement, who has provided information to Brian Daniels in 2000 and onwards, then I challenge that. I cannot challenge baldly and say you are not the mother.

THE LEGAL ASSESSOR: I have got a record of the witness saying ‘I am the mother of D.’

MR MORRIS: If that is what I put I withdraw that.

THE CHAIRMAN: As I understand it what you are really saying is that someone took Master D to see Dr Cosgrove around 1996 and wrote some letters at that time. Someone wrote some letters from 2000 onwards and it is your assertion that there are two people involved in this, two different people.

MR MORRIS: Correct.

THE LEGAL ASSESSOR: About what you say about your cross-examination I think that the evidence of this witness is that she is both the mother of D and she went to Bristol.

MR MORRIS: That is abundantly clear.

THE LEGAL ASSESSOR: The record will show your challenges that have been made. We will take it from there.

MR PEARCE: Sir, may I raise one matter. Inviting you to sit in camera I didn’t refer you to the relevant rules. You might I think properly be referred to the rules simply so that you understand your powers, not because I need to make any specific submission in respect to those. Rule 48 I think is the relevant paragraph sir.
“(1) Subject to the provisions of rule 50(5), and to the following paragraphs of this rule, all proceedings before the Professional Conduct Committee shall take place in the presence of all parties thereto who appear therein and shall be held in public.

(2) (a) If any party to any proceedings or any witness therein makes an application to the Committee for the public to be excluded from any proceedings or part thereof, then if it appears to the Committee that any person would suffer undue prejudice from a public hearing or that for any other reason the circumstances and nature of the case make a public hearing unnecessary or undesirable, the Committee may direct that the public shall be so excluded.”

I would invite you to exercise the powers for the reasons I have said. I think if I may say so sir, and I am sure you considered this already, but just so that my position is clear on this point, anything which infringes the prima facie right of the public to be present is a matter that would be considered carefully, notwithstanding the fact that there may be no objection to my application, and I am sure a matter you would consider in private before coming to any conclusion, even if it was a matter that was briefly dealt with.

THE CHAIRMAN: I had a signal from members of the panel that they would not be raising any objection to being in private session for the next part of the hearing, and I haven’t heard any objection from Mr Morris.

MR MORRIS: No.

THE CHAIRMAN: So I don’t think we need to retire to consider it. We will hear the next part in private, so the public will withdraw.

(The proceedings continued in camera – see separate transcript)

PARTIES HAVING BEEN RE-ADMITTED

MRS D

Re-examined by MR PEARCE (Continued)

THE CHAIRMAN: Perhaps before you begin, I should say that during the In Camera session we tended to use the patient’s Christian name; we should be careful and go back to Mr D.

MR PEARCE: (To the witness) Could I ask you to look at a document please, Mrs D? (Same handed)

THE CHAIRMAN: This will be C1.

MR PEARCE: (To the witness) Could I ask you to just glance briefly over that
document? Have you seen this document before?
A Yes.

Q We can read what it says, “Re: Risperidone Survey”, and it makes reference to Dr Cosgrove, it says:

“Dr P V F Cosgrove of The Bristol Priority Clinic has been treating your child with the drug Risperidone and now has over two hundred other patients on this drug”.

It goes on to deal with the fact that Dr Cosgrove and a Dr Bramble of Nottingham University Medical School feel that it is appropriate to investigate how effective Risperidone is; we can see the content as the page goes on. Mrs D, in what circumstances did you see this document, how did you come to see it?
A It was sent through the post to me.

Q And, as I understand it, you made reference earlier to a document that, for want of a better word, triggered your correspondence with Dr Cosgrove in September of 1996?
A Yes.

Q Is that this document?
A This is the document that come through, yes.

Q I want to ask you if I may about some more correspondence and in asking you about these various documents, Mrs D, I am concerned at the moment with the question of the writing on the document and whether or not it is your writing?
A Right.

Q I am afraid to say there is a whole string of documents for you to have a look through, but we will go through them page by page if we may?
A Okay.

Q The first bundle we will hand out, this will be C2, sir. (Same handed) Mrs D, the first document here is dated the 23rd September 1996, it is an address that we have seen before, a hand-written letter, “Dear Doctor Barton. I am writing to inform you that I have moved from …” and an address is given. The document runs on and on the second page of C2, “Kind regards”, and there is there a name written or signed; who wrote that letter?
A Myself.

Q And who wrote the name that appears at the bottom of the letter on the second page?
A Myself.

Q And who is Doctor Barton please?
A John Barton is a consultant child psychiatrist at Yorkhill Hospital.

Q Can I ask you to look at the next page, you will see it has got a number at the bottom, actually 152, rather surprisingly perhaps, but it has been paginated by somebody else in other circumstances. There is a document here, we see there is a name written,
“Date checklist completed: 11th March 1996; Start or end of assessment: Start; Date of birth of child:” a date is given, “Name of person completing checklist:” and a name is given and in brackets ‘mother’. Who wrote the things that are hand-written on this document, Mrs D?

A I signed the bottom of it, it is my signature.

Q Did you write the other entries?
A No, I did not.

Q The date of birth on that page, is that the correct date of birth of your son?
A It is.

Q May I ask you to look at the next page of C2, numbered at the bottom 151 headed:

C “Royal Hospital for Sick Children, Yorkhill, Glasgow. Department of Child and Family Psychiatry. Permission Slip. I hereby give permission for my child …” – the name is given – “to take part in any outings which may take place from the in-patient or day units during the hours of attendance. Date: 11th March. Signed”.

Now, first of all, who wrote the child’s name there, was it you or was it somebody else?
A It was not me.

Q And the date?
A That is my signature and the date.

Q May I ask you to look at the next document in C2 with number 27 at the bottom, dated Thursday the 4th April 1996, it has a name in the top right-hand corner, it has an address we have seen before:

D “Dear Mr. Fraser.

I am writing to you to request a full report regarding my son” – name given and there is a little bit more information given – “Regards”,

and a name at the end. Who wrote that letter?
A I did.

Q All of it?
A All of it.

Q Including the name or the signature at the bottom?
A Yes.

Q Who is Mr Fraser?
A Cannot remember.

Q And the next document, if I can ask you to look at that, number 10 at the bottom.
It is dated the 23rd September 1996, it has got an address in the top right-hand corner, the address we have seen before:

“Dear Dr Robinson:

I am writing to you regarding an appointment I missed regarding my son D”.

It makes reference to travelling to Bristol to see Dr Cosgrove and D was diagnosed as having ADHD and put on Ritalin. A little more information there and then at the bottom it says, “Yours”, and a name appears; who wrote that letter?

A I did.

Q Can I ask you to look on the very top of the document, it says ‘25/9/96 clinic’; did you write that?

A No, I did not.

Q Apart from that though, who wrote the rest of it do you say?

A I did.

Q And who wrote the name at the bottom?

A I did.

Q May I ask you to look at the next page. (To the Committee) Sir, there is no significance in the way this is bundled together I hasten to add, it just happens to be bundled in this way. (To the witness) This is a consent form to the release of medical hospital records:

“To whom it may concern. I” – and a name is given – “of” – and an address is given – “do hereby authorise that the medical and hospital records of my son” – and a name is given – “be made available as required to the GMC and to their solicitors” et cetera

And at the bottom it is signed and dated. Now, first of all, the signature at the bottom, who wrote that?

A It is my signature.

Q The date, who wrote that?

A I wrote the date.

Q Now in respect of both the name that is or purports to be your name and the name of your soon, what has been typed has been crossed out and there is a hand-written alternative spelling; who wrote that?

A That was written by John Hodgkinson, the solicitor that came to interview me.

Q And next to it on each occasion one can see two initials; who wrote those initials?

A I initialled them.

Q The next bundle of documents is one that I know those instructing me have copies
of here. Could I ask you to look at this and we will mark this document C3. *(Same handed)* *(To the Committee)* I think for the sake of clarity I should say that in my copy, and I believe every other copy, the last page is entirely blank and there is no significance in that, it has simply been photocopied with one extra sheet in and then stapled together in the same way.

*(To the witness)* Mrs D, you were asked about bringing documents to the Committee hearing today and you indicated that you had had some contact with the solicitors, but that you were already travelling and that you had not therefore been able to bring certain documents?

A Correct, I could not bring documents from 1996.

Q But have you brought with you today to this Committee hearing some documents with your name written on them?

A Yes, I have.

Q And are these photocopies of those documents?

A Yes, they are.

Q If we can just look through them again just to identify them; the originals are available, I know. The first page of C3, whatever it is does not matter, but we see there, there is a signature written and the date the 18th September 2003; who wrote that?

A I wrote that.

Q On the next page there is a document that I think relates to someone’s report card and attendance print out. It is signed, there is a hand-written name of the pupil who is a tutor group member. First of all, who signed that?

A I did.

Q Who wrote the name of the pupil?

A I did.

Q And the tutor group?

A That is already there.

Q The third page, which is not terribly easy to read, I think it is one of those copy typed documents that does not photocopy very well, but we do have the original of this carbon copy of the document here, it is some kind of delivery receipt, I think, for a tumble drier?

A That is correct.

Q And just over two thirds of the way down at two boxes it says ‘customer signature’ one above the other and we can just about see a signature there; who wrote that signature?

A I did.

Q May I then ask you to look at one final bundle of documents and for this, I think, I would be obliged to those who act for Dr Cosgrove if they could assist us with save photocopying, because I believe they have copies of this; I asked for it to be copied and I believe it had already been photocopied, and that is documents relating to the Criminal
Injuries Compensation Authority.  (*Same handed*)

THE CHAIRMAN: This will be C4.

MR PEARCE: (*To the witness*)  And the details of this document do not matter again, Mrs D, I am concerned only with some hand-writing on certain pages of them.  Page 18, which is a consent:

“I authorise and request my GP to supply any information reasonably requested by CICA in connection with this application”.

Signature and a date.  Who wrote the signature there?
A  I did.

Q And who wrote the date?
A  I did.

Q And then if you go to the very back of this bundle, which is clearly something to do with the claim to an authority arising out of an injury.  Under 13.9, “Signature of applicant”, who wrote the name that appears there?
A  I did.

Q And who wrote the date that appears next to that name?
A  I did.

Q And under 13.10, “Signature of person applying on behalf of injured party”, who wrote that?
A  I did.

Q And the date, who wrote that?
A  I did.

Q May I, I hope now fairly briefly, just ask you about one or two other matters, Mrs D?  Can I refer you to D1, I know you have an abundance of paper in front of you; I can tell you it is hand-written letters, the very first hand-written letters that were referred to you.  We know these are in reverse order in terms of time, so can I ask you to go back to the earlier letters in May of 1996.  The address that appears in the top right hand corner, which I think we are calling address one, the details do not matter, were you living at that address at that time in 1996?
A  Yes, I was.

Q Would you then go on to the first page of D1 where an address appears.  I thought there might have been some slight confusion about this, because I thought I understood Mr. Hughes to call that address three, although I think it is the second address on the file?

THE CHAIRMAN: I think it was Mr Morris that said there were three addresses.

MR PEARCE:  In any event, be that as it may, I do not think it requires any formal direction.
(To the witness) The address we see on the top of D1, top right hand corner, again I am not concerned with the details of the address; was that your address on the 23 September 1996?
A Yes, it was.

Q Reference is made to Dr Spence in that letter, “My new doctor’s name and address”; was Dr Spence your doctor in September 1996?
A Yes.

Q Could I ask you please to go to D4, it is a perfectly reasonable document to go for to ask you about this, one of the typed letters? We see a name and address in the top right hand corner of D4, it is a different address from those two I have just referred to; in December 2001 was that your address?
A Yes.

Q May I turn to another matter, please, Mrs D, and that is the attendance that you say took place at Dr Cosgrove’s clinic. Can I first of all be clear about where to the best of your knowledge that clinic was, the clinic at which you saw Dr Cosgrove?
A Well I travelled down to the Bristol Priority Clinic.

Q And where do you understand that to have been?
A I was assuming it was in Bristol.

Q You said that you stayed in a bed and breakfast?
A That’s correct.

Q Do you recall where the bed and breakfast was?
A No, but I know it was about five minutes away from the Bristol Priority Clinic.

Q And you have indicated a length of time, 15/20, I think at one stage you said 15, even 25 minutes; apart from that period of time, have you on any occasion met Dr Cosgrove?
A No.

MR PEARCE: (To the Committee) Can you just give me a moment please, sir? (Pause) I am obliged, sir. I have no further questions.

Further cross-examined by MR MORRIS

Q The last document in D2, Mrs D, is the consent document, the last page of D2 dated 12 June 2003, giving permission for the General Medical Council and their solicitors to have access to your son’s medical records. Have you seen your son’s medical records?
A No, I have not.

Q There would have been nothing to stop you seeing them if you wished to, do you accept that?
A I would.
MR MORRIS: Thank you very much.

THE CHAIRMAN: Are there any more questions at this stage from Members of the Panel? (No response) There being no questions, we will break for lunch now. There is the possibility that Mr Morris might have some further questions for you after the lunch break so that we will keep you under oath at the present time and I repeat what I said earlier, you must not discuss your evidence with anyone during the lunch break.

MR PEARCE: Sir, may we take stock as to timescales, since at the moment I have an expert witness sitting in the building waiting to give evidence. It seems to me that, if my understanding of my learned friend’s position is correct, we may be hearing some expert evidence on his behalf for the purpose of his application this afternoon; that thereafter he and I will have to make our submissions to you and you will have to retire to consider those submissions – which, no doubt, will involve the consideration of certain propositions of law as well as the factual evidence that you have heard.

If you rule in favour of staying these proceedings in their entirety than clearly I will be calling no further evidence and therefore there will be no benefit to the Professor staying. If, on the other hand, you were to rule in favour of some or all of the charges continuing, the next stage in the proceedings would be for me to open the case and thereafter, subject to which charges proceed, I would propose to recall Mrs D to give her evidence on the substantive issues – and she has travelled here from a distance, always with the intention that her evidence would be given today and only today.

It seems to me, unless I am misunderstanding the processes that are now going to take place, there seems to be no realistic prospect of Professor Taylor giving evidence today. In those circumstances, I have already made the provisional arrangement that he, assuming his evidence is needed, gives evidence by way of the video link equipment on Monday afternoon and if my understanding of the timetable is correct I would propose that I release him now and proceed on the basis that it is then that he will give evidence.

THE CHAIRMAN: I am not trying to say what Mr Morris’s case will be but I would assume that he would be making quite lengthy submissions to strike out all or part of the charges and that you would be making a counter submission. If we continue with any of the charges or all of the charges, I think it would be highly unlikely that we would be starting to take evidence today. As I understand it, you will be calling an expert witness and that could take some time. You will have some idea of the time that your submissions would require.

So I think it is safe enough to let Professor Taylor stand down for today. If we were to proceed with some or all of the charges, the first stage would be for Mr Morris to respond to the charges as to whether any or all of them are admitted and then you would present your case. I think I am safe enough in saying that Professor Taylor can be stood down.

MR MORRIS: I respectfully agree with that.

THE CHAIRMAN: At this stage we will break and we will return at 2 p.m.

(The Committee adjourned for lunch)
Sir, I have no further questions to put to Mrs D.

THE CHAIRMAN: I assume you have no further questions either, Mr Pearce.

MR PEARCE: No, sir.

THE CHAIRMAN: You are now excused, Mrs D. If the case continues then I assume you will be giving evidence at a later stage. At this point I would ask you, Mrs D, to leave the room.

(The witness withdrew)

MR MORRIS: I call Mrs Marsh.

FIONA ELIZABETH MARSH, Sworn

Examined by MR MORRIS

Q Mrs Marsh, are your full names Fiona Marsh?
A Fiona Elizabeth Marsh.

Q And could you give the Committee your professional address, please?
A The address is Lapwater Hall, Middle Road, Ingrave, Brentwood, Essex.

Q What is your occupation and what are your qualifications?
A I am a question document examiner, otherwise known as a forensic document examiner. I have a Bachelor of Science degree, a Master of Science degree, and I was trained in the scientific examination of documents and handwriting at the Metropolitan Police Forensic Science Laboratory.

Q How long did you work there for?
A I worked there for, I think, eight years.

Q I think you left the Forensic Science Laboratory in 1988. Since that time, how have you worked?
A I have worked as an independent document examiner.

Q Can you tell us the sort of work you have done and for whom in terms of your independent career?
A My clients include: I work for prosecuting bodies, including the Metropolitan Police, the City of London Police, various police forces, Trading Standards, Ministry of Defence, and I have worked for prosecuting bodies abroad, for the Gibraltar Police, people in Australia, Philippines and various other countries. I do criminal defence work, where most of my clients are solicitors but I do some work for private individuals, and I do civil work which includes work for banks, insurance companies, corporate businesses, whoever.

Q I think on Monday of this week, 19 January of this year, it is right that you were
shown a number of documents and asked to comment upon them?
A     Yes, I was.

Q     I think following your sight of those documents on Monday the 19th you have compiled a report as to what you have seen and your conclusions about what you have seen?
A     Yes, I did.

Q     You have been here today listening to the evidence, during the course of which a number of other documents have become available within the hearing, is that right?
A     That is correct.

Q     Those are identified in two groups, but had you seen those other documents before today?
A     No, I had not.

Q     Have you had an opportunity to look at them over the adjournment?
A     I have made a cursory examination of a number of additional documents.

Q     I want first then to identify those documents which you were able to see on Monday in more leisured circumstances and on which you have prepared a report. Could you have, please, D1, D2 and D4?
A     These were the documents I examined on Monday.

Q     Can I just go through these to make sure that you have identified the ones you saw on Monday? First of all, looking at D1, did you see the three handwritten letters dated 26 April, 27 May and 23 September 1996?
A     Yes, I did.

Q     Turning to D2, did you see the letter dated 18 August 2000, which is typed and signed by Mrs D?
A     Yes, I did.

Q     With the addition of a “p”?
A     That is correct.

Q     Turning to D4, did you see the letters dated 11 December 2001 and 21 June 2001?
A     Yes, I did.

Q     Together with the copy driving licence attached to the letter of 21 June 2001?
A     Yes, I did.

Q     I want you to begin with your views about that documentation first of all and then I will turn to the additional documentation that you have seen this morning for your views on that. First of all, was all the documentation that you saw on Monday original?
A     No, two of them were copy documents.

Q     Are you able to identify which were the copy documents that you saw?
A     May I refer to my notes?
Q  Just tell us about those notes, please.  When did you make your notes?
A  They were contemporaneous with my examination.

MR MORRIS:  *(To the Committee)* I wonder if the witness may be allowed to refresh her memory from her notes?

THE CHAIRMAN:  Yes.

MR MORRIS:  I am grateful.

THE WITNESS:  The typed letter dated 18 August 2000 was a copy, as was the driving licence.

MR MORRIS:  So that is D2 and the driving licence, D4.  I think what is common to all the documents is that there are signatures on these documents and it was those signatures that you were asked to make a comparison of, is that correct?
A  That is correct, yes.

Q  Before you begin to give evidence about those signatures and your comparison of those signatures, I just want you to help the Committee as to any difficulty you might have in discussing those signatures if you are asked to maintain the anonymity of the signatory.  Is this going to cause you problems?
A  I have never had to give evidence on handwriting before anonymously.  I can give evidence, I hope, in general terms but if you want any sort of detail of the letters then I cannot keep it anonymous.

MR PEARCE:  If I can just come in there, I make it clear now that if this evidence is going in the direction I anticipate it is, then I certainly by way of cross-examination think I clearly have to ask about details, individual letters and names – matters which would clearly render the idea of anonymity not workable.

THE CHAIRMAN:  Basically what you are suggesting to us is we should hear this evidence in camera.

MR MORRIS:  I feel otherwise the anonymity is inevitably going to be breached.

THE CHAIRMAN:  We agree to that.

Sadly, I have to ask the public to leave once again.

*(The proceedings continued in camera – see separate transcript)*

D2/40
GENERAL MEDICAL COUNCIL

PROFESSIONAL CONDUCT COMMITTEE

On:
Friday, 23 January 2004

Held at:
Barnett House
53 Fountain Street
Manchester M2 2AN

Case of:

PATRICK VERNON FINN COSGROVE MB BS 1968 Lond
(Day Three)

Committee Members:
Professor N Mackay (Chairman)
Dr A Hamilton
Mr J Matharu
Dr B Stanley
Mr R Briden (Legal Assessor)

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MR D MORRIS, of Counsel, instructed by Messrs RadcliffesLeBrasseur, appeared on behalf of Dr Cosgrove, who was present.

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

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

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THE CHAIRMAN: Good morning. Mr Morris?

MR MORRIS: Sir, I think when we parted on Wednesday Mrs Marsh was in the witness box. She is sitting at the back of the Committee room. Before she moves from that position, I would like to place before the Committee a further report that she has prepared on the additional material that was submitted to her on Wednesday. (Same handed)

THE CHAIRMAN: That will be D10. Did we have an earlier report?

MR MORRIS: No, sir, she gave that report orally and I do not propose to put the earlier report in. It is a short report and I propose to read it to you and then to comment to you. It is entitled “Further Report on Examination of Signatures in the Name of [Mrs D]”.

THE CHAIRMAN: There are members of the public here and we were hearing evidence about handwriting in private.

MR MORRIS: I think for the purposes of this report I can deal with it in public session.

THE CHAIRMAN: Thank you. It is Mrs D we are referring to.

MR MORRIS: Mrs D.


I have examined these additional signatures, fourteen in total as two of the documents have been signed twice, in conjunction with the seven signatures examined previously and referred to in my report dated 19th January 2004.

The seven signatures examined previously could be divided into two distinct groups with three signatures dated 1996 falling into one group and four signatures dated between 1999 and 2001 forming a second group.

The additional fourteen signatures examined extend the range of variation considerably to that seen in the original seven signatures.”

Sir, I do not believe as part of the document that you have, you have an additional sheet in the form of a template which you were given last time. I would ask that that be circulated too. (Same handed)

THE CHAIRMAN: D11.

MR MORRIS: Having a template may assist in understanding what she is saying here:

“The additional fourteen signatures examined extend the range of variation considerably to that seen in the original seven signatures.

D3/1
Additional variations include the use of upper case “H” in the surname of some of the signatures e.g. on the handwritten letter dated 23 September 96, on the Childhood Behaviour Checklist dated 11th March 1996 and on the consent form dated 17/2/02. This feature is also found in the two signatures on the Delivery/Collection Sheet dated 16 January 16/01/04. Furthermore, these two signatures, dated 16/01/04 are considerably more abbreviated than all the other signatures examined. More significantly some of the additional signatures cannot be clearly placed into either of the two groups as before, but show a considerable amount of overlap between the two groups effectively bridging the gap.

It is apparent from the handwriting and the signatures on the handwritten letters dated 1996 that [Mrs D]’s writing and signatures are quite variable. Having examined additional signatures in the name of [Mrs D] on a variety of documents and seeing the extended range of variation it is probably that all the signatures were written by the same person. However, as this signature is so variable and simple in its method of construction it is relatively easy to copy. Consequently if any of the signatures were to be considered in isolation I cannot entirely exclude the possibility that it may be a copy of [Mrs D]’s signature. However, I found no evidence that this is the case.

I understand my duty to the court and I have complied with that duty.

I believe the facts stated in this witness statement are true.”

She signed that on 22 January 2004.

Sir, the upshot of this further report and Mrs Marsh’s consideration of the additional material is set out in her final substantive paragraph, where she says that on seeing this extended range of variation it is probably that all the signatures were written by the same person. That is her evidence and I do not seek to subvert that evidence and this is an agreed document which is now before the Committee.

In the light of that, neither I nor Mr Pearce would seek to ask her further questions. Obviously, she is still the Committee’s witness or before the Committee and if the Committee wish to ask her further questions you must be entitled to do that. For my part, I do not seek to ask further questions and I do not believe Mr Pearce does, but she is here and available if questions are required.

MR PEARCE: So long as what is said and read out in that report and clearly signed by Mrs Marsh is taken to be her as though she had given that evidence before you, then I do not seek to cross-examine her.

THE CHAIRMAN: I assumed that was the position.
There are no further questions from the Panel, Mrs Marsh, so you can now stand down. I am sorry you have been brought back for another day. Thank you very much for coming down.

MR MORRIS: Sir, at this stage, all things being equal, I wish to commence or recommence (I am not quite sure the best way of putting it) my submission on abuse of process. I regret to say that not all other things are equal and I think the Committee may be faced with a further hiatus. May I explain the position? In the material that was disclosed by the Council on Monday, that is to say the internal memoranda which I sought and which were procured by the Council and disclosed to the defence team on that day, the prime purpose of which was to see whether there was any express matters that relate to Mr Daniels and the Citizens Commission on Human Rights and whether there was any involvement by them in the decision to refer the six original complaints to the Registrar at the end of September 2002.

It is also apparent from that material that the original six cases, or at least a majority of them – maybe not all of them but the majority of them – were, in 2001, referred to the Performance procedures of the General Medical Council. It is shown that a medical screener took that decision at the beginning of 2001 and, indeed, that Dr Cosgrove was notified of that decision in 2001 and probably in May 2001.

It is apparent also from this material that in February 2002 the matters were considered again by another medical screener of the General Medical Council, who took a different view, saying that they should be referred to the Preliminary Proceedings Committee and therefore be sent down the Conduct route.

There is a suggestion in the various memoranda that went to and fro within the GMC about this decision that that decision could be justified on the basis that further information had come to light about Dr Cosgrove. However, on the face of the documentation that I have all the complaints date from 1999, 2000 or earlier and it does not appear to me that there was any further fresh information that would justify the Council in deciding to take a wholly different approach to the treatment of this information and complaints.

If that is right, it would, in my submission, amount to an unfair use of the investigate powers of the General Medical Council and would amount to an abuse, which I would seek to lay before you.

I have told Mr Pearce about this this morning and, quite understandably, he is not in a position to deal with my concerns at this stage and he would like time to investigate whether there is in fact additional material which would have justified a screener taking a wholly different course from the one that was originally promulgated and communicated to Dr Cosgrove.

If there is substantive additional material that was basis for that decision then I will not proceed with any submission based on this point. If there is not, I would seek to proceed with this submission and it would not be right or fair to Mr Pearce, I believe, for me to begin my submission now and then for us to have a pause while investigations are made. I think the view he would take is it would be best if that investigation were done now.
I am not sure how long that is going to take him. I am not sure whether he can assist in that regard, but I am sorry to put this problem before the Committee, but I must do so.

MR PEARCE: We may perhaps be fortunate that we have a little leeway in time, sir. Of course that is no ground on which not to proceed with expedition. As my learned friend rightly says, he alerted me to these matters this morning, I have had no more than a cursory view of the documents. His point raises a number of questions, not least the fundamental factual question as to whether there was a decision to refer to performance and then a change of that decision. Secondly, if there was a change of decision, on what basis that change of decision was made. Thirdly, whether that change of decision was based on fresh information or not could be justified. Fourthly, it seems to me, whether, even if it could not be justified, it necessarily leads to any unfairness, sufficient to ground an application for abuse.

Those are each matters that I would need to consider. The most fundamental of those, it seems to me, is to seek what decisions were made and the basis upon which they were made and that will undoubtedly take a little time. In the light of what my learned friend has to say I cannot resist his right to raise the argument and in those circumstances it seems to me I am bound to seek to respond to it by investigating the points he makes.

It seems to me the proper way for us to proceed at the moment is for you to allow me some time, and I think something like an hour in the first place, in order to give me the opportunity to see what the point is, speak to those, presumably in London, who may know the answers, so in about an hour’s time I hope to be in a position to say to you this is the way it appears to be going. I am not saying I will have the material, if material there be that is relevant to it, but at least I hope to be in a position to say I know where I am going. I can see a number of possible options, one of which is that I may seek to call one or more witnesses. Those witness will no doubt not be available today. That may be a possibility. I simply do not know what material there may be, which is why I seek the indulgence of the time; to try to find out what there is and, I must say, to try to establish whether there is any authority on this point. I am not as familiar with the screening process as perhaps others who work in the GMC are, because I have no part in that process. I only come in at this stage when it has already been done. I have to confess I have not had a case where any part of the screening process has been challenged. It has been suggested there is one authority, one decision in this area, I think a judicial review decision, although I am not sure it has any relevance to this point. So there are legal questions as well. But in the first place I am more concerned to try to understand the factual position so I can lay at least in bare bones what we will be saying in the point before you. We can then take a decision whether we proceed on this. It is fortunate that we do have some more leeway of time than we might in another case.

THE CHAIRMAN: I think we are setting a record in GMC terms (Inaudible) but be that as it may. We have got to do it appropriately. So shall we adjourn at the moment until 10.30 and then review the situation thereafter. Certainly if witnesses have to be called it is Monday before that can be done, it may very well before Monday before you have your case ready. Let us review the situation at 10.30.

(The Committee rose for a short time)
MR PEARCE: Sir, thank you for the time. I have had a very lengthy conversation with a lawyer on the legal issues and, for my benefit, the procedures relating to screening. It is not straightforward, it is not easy, like a lot of these matters. I have also had an opportunity to look through all of the documents that we have here on the screening process that took place here and the explanation for some of the issues that my learned friend either has raised or, I anticipate, will rise is not apparent from those documents. There are clearly some substantial unexplained areas.

Sir, what I will invite you to do is to retire now and return on Monday morning. Can I tell you what I am going to do, if you acceded to my request, between now and Monday morning; that is that I propose to spend the rest of the day, as long as it takes today in seeking to identify what, if any, further documents there are and what, if any, further knowledge there is to explain the screening process that has taken place here with a view to putting any documents and, secondly, any information to my learned friend so that he can consider whether he proceeds with the point and, if he does, so at the I can seek to have a available before you on Monday morning all information, be it by way of witness evidence, documents or whatever else, that I would seek to call to deal with this a point.

It seems to me, Sir, and particularly, but not only, I have say, having regard to the fact I believe you are going to rise at 3 o'clock, that by the time I have the answers to these inquiries it will be so late that we would frankly feel that it is Monday morning any way, at best I will have identified a number of documents that will allow us to start oral submissions and I anticipate that I will not have that before 2o'clock and whether you really wish to start hearing an abuse argument application for an hour only. As I say, given the circumstances in this case we do have a little indulgence of time, you may well think the time is better spent that way. The aim is that for us to be ready to go first thing Monday morning.

THE CHAIRMAN: I think that is perfectly reasonable. From what you say you will require significant amount of time to acquire the information, you will have to share it with Mr Morris. There is no guarantee that you would be ready by 2o'clock or 3 o'clock. The issue of witnesses?

MR PEARCE: That depends on what the information is. That depends on who is available to say what. There has been some changes of personnel. It may well be that there is no greater information on some of these points than can be discerned from the documents. It may be that there are people with knowledge of the decision making process and can speak for it. I need to identify what is there is and who there is and I also need to identify their availability. My intention would be to line up any evidence that I seek to call before Monday morning so that we can produce it then and deal with them from there.

THE CHAIRMAN: I do not think there is any option but to adjourn today and reconvene on Monday. Slight worry about Monday and Tuesday, there are forecasts of snow but we will take that as it comes. Let us not be pessimistic!

MR PEARCE: It will not snow in Manchester. If never does, it is too warm!

THE CHAIRMAN: Mr Morris?
MR MORRIS: Sir, I have nothing to add. I am grateful for the steps my learned friend is taking.

THE CHAIRMAN: So we will adjourn and hopefully reconvene on 9.30 Monday morning.

(The Committee adjourned for the day to reconvene at 9.30 Monday morning)
GENERAL MEDICAL COUNCIL

PROFESSIONAL CONDUCT COMMITTEE

On:
Monday, 26 January 2004

Held at:
Barnett House
53 Fountain Street
Manchester M2 2AN

Case of:

PATRICK VERNON FINN COSGROVE MB BS 1968 Lond
(Day Four)

Committee Members:
Professor N Mackay (Chairman)
Dr A Hamilton
Mr J Matharu
Dr B Stanley
Mr R Briden (Legal Assessor)

MR D MORRIS, of Counsel, instructed by Messrs RadcliffesLeBrasseur, appeared on behalf of Dr Cosgrove, who was present.

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

(Transcript of the shorthand notes of TranscribeUK
Tel No: 0208 614 5799)
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THE CHAIRMAN: Good morning. Mr Morris, or is it Mr Pearce?

MR PEARCE: I think it is me briefly first, sir. You will recall we had reached the position on Friday where my learned friend had raised an argument which I sought your indulgence to have sufficient time to consider in detail and to take instructions on. May I say in the first place that I was not able to take those instructions until well into the afternoon due to the non-availability of the appropriate person at the Council offices, and so, if I may say so, the decision to put matters back to today was justified in the event.

Having had the opportunity to take those instructions and to consider the law in respect of screening, it is not our intention to adduce evidence or documentation in respect of the screening process that has taken place here. It is our submission, and no doubt this will be developed in due course in the light of my learned friend’s abuse of process argument, that it is not appropriate for the screening process to be examined or reviewed at this stage.

A decision at the screening stage may very well be capable of challenge by way of application for Judicial Review, an application that would be dealt with by the Administrative Court in accordance with its procedures. This is not the appropriate forum, we submit, to make any such challenge. You will no doubt have it firmly in your minds that we are dealing with a screening decision taken very close to two years ago now, since when these proceedings have followed their usual and, we say, proper process through the Preliminary Proceedings Committee and into this Committee. We say to now seek to challenge that decision, which is an administrative decision that comes before everything that has happened since, is simply not a challenge that can properly be taken before this Committee, but is one that, if it were ever to be challenged in any way, should have been or should be challenged by way of Judicial Review application in the Administrative Court.

My learned friend has indicated that he will develop his arguments in respect of abuse of process in this regard and I will no doubt respond to those in due course. That, in the short term, is to explain our position today and why we have reached that decision.

THE CHAIRMAN: Thank you very much. Mr Morris.

MR MORRIS: Sir, I am at long last going to make the substantive submission that I wished to make early on last week in relation to, it now transpires, three separate matters. The first submission is the one I outlined to you last week. If you have a copy of the transcript for D1/9 F I outlined there in a nutshell what my submission was going to be, namely, that under the aegis of the Church of Scientology’s organisation, the Citizens’ Commission on Human Rights, a complaint or information had been provided which is fraudulent, inasmuch as it does not come from whom it purports to come from, namely the mother of patient D.

I am now going to elaborate on that submission beyond saying that that head of charge should not be allowed to proceed, because it amounts to an abuse of the process of your Committee, and that it has a knock on effect in relation to the remaining charges. I am also going to be submitting as a result of developments last week and the disclosure of documentation by the Counsel that there has been effectively a breach of promise on the
part of the Council, inasmuch as in relation to the charges that were notified or heads of charge that were notified in the rule 6 letter of 1 October 2002, either the doctor had been given an indication that no further action would be taken in relation to various complaints, or that the action that would be taken was that those complaints or information would be considered by the performance processes of the Council and not the disciplinary conduct processes of the Council. The breach of that indication or promise itself is a free standing abuse of the process of your Committee.

My third submission is that because the Council on Friday took the view that no further disclosure of material was warranted, material that in my submission is relevant to the conduct of the defence of Dr Cosgrove, that too stands on its own as an abuse of the process of this Committee.

Can I return to the first submission in relation to head of charge 6 concerning patient D? It would perhaps assist if at this stage I recapitulated on the law that I set out on the first day of this inquiry. It is helpfully set out in the transcript at D1/19 through to D1/21 letter D. I do not propose to read through it again. That would be a complete waste of your time. I am sure that you will have it fairly well in mind.

My submission in relation to the law on this matter is as set out at the bottom of D1/19 F.

“Power to stay proceedings for abuse of process has been said to include the power to safeguard an accused person from oppression or prejudice…”

That is a reference to the case of Connolly.

“…and has been described as a formidable safeguard developed by the common law to protect persons from being prosecuted in circumstances where it can be seriously unjust to do so. An abuse of process was defined in the case of Ho Chi Min as something so unfair and wrong that the Court should not allow a prosecutor to proceed in what in all other respects is a regular proceeding.”

That was elaborated in the case of Baring, which was a case under the Company Directors’ Disqualification Act 1986 where the Court of Appeal said that a Court may stay proceedings where to allow them to continue would bring the administration of justice into disrepute among right thinking people, and that this would be the case if the Court was allowing its process to be used as an instrument of oppression, injustice or unfairness.

What I submit I did on that first day at D1/20 F to G is that if there is bad faith demonstrated in relation to the bringing of charges other than head of charge 6, there is ample authority for granting a stay properly on the grounds of abuse of process, and that the lack of bad faith does not have to be found in the heart of the prosecuting body. It can take effect even if the body itself is an unwitting victim of that bad faith. The body here is, of course, the Council and it has been, in my submission, a victim of the bad faith of either the Commission on its own or the Commission together with Mrs D. There is a reference there to paragraph 4-63A of Archbold which I need not trouble the learned Legal Assessor to look at now. The reference is set out in the transcript at letters F to G on page 20.
Can I turn to head of charge 6, patient D? The effective informant in that case was the Commission, the Citizens Commission for Human Rights. My primary submissions was as succinctly summarised by your Chairman on D2/29E, when he summarised the position thus:

“What you are really saying is that someone took Master D to see Dr Cosgrove around 1996 and wrote some letters at that time. Someone wrote some letters from 2000 onwards and it is your assertion that there are two people involved in this, two different people.”

I say that was a correct way of putting it, in my submission.

Notwithstanding the evidence of Mrs D and Mrs Marsh, the handwriting forensic expert, I do not resile from that submission. You are not bound by the evidence of an expert. It is opinion evidence and you, the Committee, have to make up your own minds. I am sure Mrs Marsh would have been the first to accept that the forensic examination of handwriting is not able to deliver certainty in its conclusions – not always – and that additional material can lead to remarkably different conclusions.

You had a classic example of that when, on the first day she gave evidence about her assessment of the handwriting signatures seen or made in 1996 and those made in 2000 and 2001, where she concluded on the basis of that material that there was no evidence to connect the two and then, when she returned having seen additional material, she had come to the conclusion that the range of variation was such that it was probable that all the signatures were by the same person. You will have to make up your mind on that evidence.

I wish to add an alternative submission in this light – I say “in this light” – in the light of the evidence produced by Mrs Marsh. If you are not satisfied on the balance of probabilities - which, in my submission, is the test you have to apply here because the onus of proof I accept is on the Defendant in this submission – if you are not satisfied on the balance of probabilities that there were two separate authors to those signatures and that they were on balance probably the work of the same hand, then what I submit is that that author, Mrs D, who gave evidence before you, has been manipulated such that in reality the complaints embodied in first of all the letter of August 2000 – D6 - and the subsequent witness statement of August 2003 – D8 – are not effectively her documents and they are not made with her authority, notwithstanding her assertion in evidence before you to the contrary.

That complaint as embodied in that letter and witness statement is not her complaint. It is the Commission’s and, in that respect, is a fraudulent complaint.

I wish to give the Committee the reasoning behind that submission. The first is to do with the letter of 18 August, D6, an unsigned letter written in the name of Mrs D, spelt with a “p”, you will note.

You will recall Mrs D’s evidence about that, that that was a letter she had written in manuscript in her own hand but that it had been typed by Brian Daniels of the
Commission. My submission is that that letter was not drafted by Mrs D; it was drafted by Brian Daniels of the Commission, for these reasons.

One – if he had been given a manuscript by Mrs D with her name spelt correctly, both at the top and at the bottom where there is space for her signature and her name appears and if her son’s name had been spelt correctly, then it is inconceivable that Mr Daniels in typing that letter up would have mistakenly transcribed that name in three different places. You will see it at the top right of page 1 of D6, you see it in the son’s name when it was set out in full in the first paragraph of that letter and you see it at the end of that letter.

That this is Mr Daniels’ work is further supported, in my submission, by the letter he wrote to the Council on 28 June 2000. This is not a letter that you currently have and I will hand it to you now.

THE CHAIRMAN: This will be D12. (Produced)

MR MORRIS: This is the first letter that the Council received and it related to the survey that Dr Cosgrove was carrying out together with Dr Bramble. The survey letter you will see is C1 and it also refers to an article in the Daily Express where Dr Cosgrove is quoted.

The significance of it, though, from the point of view I am taking at the moment, is that you will see in this first letter Mr Daniels spells the patient’s mother’s name incorrectly with the letter “p”. You will see that in the third paragraph on the first page and you will see it at the bottom of the second page, at the very bottom where he notes that copy is being sent to her, “c.c. Mrs D”.

Finally in relation to that letter D6, of course the obvious point that the letter is not signed by the ostensible author.

THE CHAIRMAN: That is D6 you are talking about?

MR MORRIS: D6, I apologise. Yes, D6. In my submission it is inconceivable that such an important document, written in manuscript by Mrs D as she says it was, typed by Mr Daniels, sent back to her for perusal before sending – which is what her evidence was, that she did, indeed, see the typed letter before it was sent out – should not be signed by her.

You will recall she gave two explanations as to why it was not signed. Those explanations were, in my submission, contradictory. First, she said she did not sign it because it was typed and there was no need. One has to ask rhetorically if that is the case, then why bother to sign the other letter of 18 August giving disclosure, or authorising disclosure of her records? That is dated 18 August too and I think that is D2.

Her second explanation was that it was an oversight. Neither of those, in my submission, are realistic and, indeed, they both contradict each other.

The reality is, I suggest, that Mr Daniels drafted that letter and sent it to the Council
without it ever being shown to Mrs D, the mother of the patient.

The second reason why I say that this complaint, Head of Charge 6, is made without the mother’s authority, is, I suggest, that he drafted and typed the consent letter of 18 August – that is D2. That, indeed, is accepted by Mrs D. You will notice if you compare D2 with D6 - the letter I suggest that Mr Daniels drafted himself and sent without reference to the patient – you will notice that the layout of the address of the sender at the top right, the address to whom it is going to be sent, the layout of where the date is put and the reference, are identical.

You will notice too in D2 that again we have the mis-spelt name and we also have the assertion that Dr Cosgrove is practising at the Bristol Priority Clinic in Bath, Avon. Clearly again, in my submission, a document written without reference to the mother of the patient.

But this is a letter that Mrs D says was not drafted by Mr Daniels. It was written by herself in manuscript and typed-up by a neighbour who lived about ten minutes away from her. I suggest that is false. It is clearly written by the person who drafted the letter - the other letter of 18 August, the letter of complaint - and I suggest that that was Mr Daniels.

The third reason why I say this Head of Charge is not made with the mother's authority is Mr Daniels' letter written to the GMC on 31 October 2000 which we see at D7. This is giving information that was being sought by the Council. Mrs D said that this was information she gave to Mr Daniels. He again spells her name incorrectly but, much more significantly than that, he says in answer to the specific question as to where the treatment took place that it was at the clinic in Bath. So, again I suggest that this was a letter formulated by Mr Daniels without reference to the mother certainly in relation to that specific critical issue.

Mrs D's explanation for that mistake, because it obviously was a mistake by her if she was giving the information, was that, "My geography was not that good"; in other words she mistook Bristol for Bath although she accepted that they are completely different cities.

The real explanation I suggest behind this is that Mr Daniels got that information from C1, the Risperidone Survey document sent out by Dr Cosgrove, where you see at the top that the Doctor's address is given, or the Bristol Priority Clinic's address is given, and it is the correspondence address in Bath. And Mr Daniels understandably, but wrongly, assumed that that was where the treatment was taking place.

Mrs D, in my submission, when giving evidence before you, attempted to shoulder all the responsibility for these errors which continued further into the Witness Statement itself; for example, when it is stated in the Witness Statement that Dr Cosgrove saw them at a hospital in Bristol when all agree now that it was not a hospital but that it was a clinic. And, in shouldering that responsibility, she is trying to conceal the fact that those errors were Mr Daniels' errors and that he and not she was the effective source of this complaint.
The fourth reason why I suggest that this complaint is made without her authority is that Mr Daniels and his Commission have demonstrated over a period of time a motivation to act on matters that concern them without appropriate authority, and this is what happened here. This is the way, in my submission, that Scientologists operate.

You will recall the sequence of events here. That Mrs D, the mother, got in touch with the organisation "Overload" in Edinburgh which was being run by Janice Hill. "Overload" and Janice Hill, I suggest, are an organisation and a person who are sympathetic to the aims of Scientology and sympathetic to the aims of the Commission such that her organisation, of which I suggest she is the Founder, and her comments on the Commission are to be found on the Commission's website. And if I could hand a copy of that in, please.

THE CHAIRMAN: This will be D13.

(Copies of the document were distributed)

MR MORRIS: I am afraid that the photocopying is not brilliant but, on the top left of the photograph of the page on the Website, there is a logo. I have got the original here and it is the logo of the Citizens Commission on Human Rights, although that is not legible there.

However, on its website we have the entry for:

"Janice Hill, Founder of ‘Overload Network’ in Scotland 2000
A network for parents which educates them on the stigmatization of psychiatric diagnoses and drugs given children",

where she is quoted as saying:

"CCHR is a sane prescription for what ails our children, our schools and our communities. It is a no-nonsense, say-it-the-way-that-it-is. type of group. I hope that every parent will continue to have access to CCHR's outstanding up-to-date factual data. I also hope that every parent and teacher takes CCHR's superb advice to heart. Do not allow harmful psychiatric diagnoses, treatment and drugs to ruin another child's life, another child's future".

Janice Hill here in this case was concerned about the drugs being prescribed by Dr Cosgrove and was concerned enough to inform Mr Daniels, who in turn, Mrs D said, contacted herself, and I do not ask you to turn it up but the reference to that in the evidence is in Day 2 of the transcript, Page 11, Letter B.

His concern according to Mrs D - that is Mr Daniels' concern - which she asserted that she also shared, was and I quote Mrs D's evidence, "To stop this man doing this any more", and that is Day 2 at Page 12. "And that was going to be done ...", and again I
quote from her evidence, "... by exposing Dr Cosgrove's treatment of over-medicating young children ...", plural I emphasise, "... by writing to the General Medical Council", and that was her evidence at Day 2, Page 15, Letter A.

I hasten to interpolate here that you will notice from the Notice of Inquiry that that notice does not allege over-prescribing, or mis-prescribing, of any drug by Dr Cosgrove.

It is my submission that the Commission's methods mirror the Church of Scientology's approach to psychiatry. It is perhaps a little time since you had the chance to look at the Foster Report, or "Enquiry into the Practice and Effects of Scientology", at D3, but may I just remind you of what I suggest is the Scientologists' approach to Psychiatrists. Mr Foster categorised them at Paragraph 174 in Chapter 7 as representing one of those groups who seem to have become enemies of Scientology.

And the approach to be taken to criticism made of the organisation is helpfully set out under Paragraph 181, under the heading "Doubters outside the fold", which is a letter - an internal letter within the organisation - from Mr Hubbard, the Founder of the organisation, where he says in the middle of that page:

"Anyone proposing an investigation of or an 'Enquiry' into Scientology must receive this reply and no other proposal: 'We welcome an investigation into (Mental Healing or whoever is attacking us) as we have begun one ourselves and find shocking evidence'."

And then he goes on to say ...

THE CHAIRMAN: I am sorry, Mr Morris, but where is that?

MR MORRIS: We are at Paragraph 181.

THE CHAIRMAN: Right, thank you.

MR MORRIS: It is under a subheading "Doubters outside the fold".

THE CHAIRMAN: Yes, thank you.

MR MORRIS: And in response to enquiries, or as he sees it attacks, the correct procedure he says is:

“(1) Spot who is attacking us.

(2) Start investigating them promptly for FELONIES or worse using own professionals, not outside agencies.

(3) Double curve our reply by saying we welcome an investigation of them.

Start feeding lurid, blood, sex crime actual evidence on the
attackers to the press. Don't ever tamely submit to an investigation of us",

and it goes on in the same breath and manner for the whole of the next page and, indeed, for the whole of the rest of that letter.

He continues to write in that vein if you look under -- well, in fact it is under the same paragraph. If you go on from the end of the letter I have been referring you to for four pages, you get an internal memorandum dated 9 February 1966, "Secretarial Executive Director: Enquiry Rumour UK", and it starts I hope the Committee have it:

"The 'news' that some lord [Lord Balniel] is 'going to ask a question in the House as to why the Health Minister here does not conduct an Enquiry into Scientology like in Melbourne".

And then he comes up with such comments as:

"4. Obviously we could have had a ball and put psychiatry on trial for murder, mercy killing, sterilisation, torture, and sex practices and could have wiped out psychiatry's good name".

Over the page at sub-paragraph 4,

“Well, scientology isn’t like psychiatry. In psychiatry they think adultery is a cure for.” You guess it. Curve every answer with answers that make lurid press to psychiatrists cost.”

At paragraph 184 a few pages on, we come to the category of enemy entitled “Psychiatrists.” Mr Foster days this,

“The Scientology leadership sees in psychiatrists an especially virulent class of enemy. It is certainly true that psychiatrists in general have expressed no approval of Scientology theories and tend to regard Scientology processing as potentially harmful, especially to unstable minds.

The Scientology leadership has reacted energetically: - ‘Hubbard says more psychiatrists are nuts than any other section of the community, he is stating an observable, statistical truth.”

It goes on in that light for further pages. At paragraph 186, the final heading under the heading dealing with psychiatrists, there is reference to their attempt to take over organisations and one is specified here, the National Association of Mental Health, a UK body, by joining it in large numbers.

That is the philosophy behind Scientology, a philosophy that is endorsed, in my submission, by the Commission. For example, if you look at the letter heading on D12, it is an organisation established by the Church of Scientology to investigate and expose
psychiatric violations of human rights. Copyright is claimed at the bottom of that page,

“All rights reserved. Scientology is a trade mark and service mark owned by Religious Technology center and is used with its permission. Scientology is an applied religious philosophy.”

Their methods, and when I say “their” I am referring to the Commission’s methods, are to make unsubstantiated allegations. One particular victim of those allegations was Professor Sir Martin Roth, a Psychiatrist in Newcastle. Can I hand up material about that? (Same handed)

THE CHAIRMAN: This will be D14.

MR MORRIS: There are in fact two pages to D14.

MR MORRIS: This was a defamatory claim, I suggest, that was made in November 1988 against the Professor. The article containing the libel is set out there in the first and second paragraph,

“Dozens of people of Tyneside could have brain damage from experimental drug tests carried out almost 20 years ago.

The Sussex based Citizens Commission on Human Rights claims Geordie guinea pigs were tested with the hallucinogenic drug LSD by a team headed by world renowned psychiatrist Sir Martin Roth at Newcastle University in the early 1960s.”

The upshot of that was, as can be seen in the e-mail setting out a press cutting from the Northern Echo of 22 June 1990, when the Professor accepted very substantial libel damages over a highly defamatory newspaper article. It had suggested that he had been involved in experiments on humans that led to many deaths and injuries. The front page story in the weekly Newcastle Times was headlined, “Dozens brain damaged by LSD.”

“I claimed to be an account of the findings of a report by a group called The Citizens Commission of Human Rights which is part of the Scientology organisation. The November 1988 article made three highly defamatory and utterly false allegations about Sir Martin.”

I need not go on. That this particular leopard has not changed its spots, I suggest is confirmed by the current website for the organisation.

THE CHAIRMAN: This will be D16. (Same handed)

MR MORRIS: This is a print out of the front pages of the Commission’s website. It was taken on 23 January 2004. Again, its statement is legible on the first page, “Investigates and exposes psychiatric violations of human rights.” Over the page, and unfortunately it
has not come out on the photocopy, there is a black box in the middle where you can read, “There is no science to psychiatry only …” In your photocopies what cannot be read is what appears beneath and this is something that changes every few seconds. The words that appear and can be seen on this original print out copy which I will hand up in due course for your observation, but it can be seen faintly here but clearly. These words alternate,

“There is no science to psychiatry only misappropriation.
There is no science to psychiatry only pretended authority.
There is no science to psychiatry only betrayal.
There is no science to psychiatry only graft.”

There are other words that appear there. These include,

“There is no science to psychiatry only abuse.
There is no science to psychiatry only greed.”

Can I hand up the original so that the Committee can see those words that appear in the black box. I do not invite them to do so now unless they wish to. (Same handed)

THE CHAIRMAN: I think this is the same.

MR MORRIS: It is D16, but it is the original print out. The final suggestion, and I only make it as a suggestion, or a piece of evidence that I would suggest points to the continuing ability of this organisation under its executive director to misrepresent people is to be found in two letters written by Mr Daniels dated 28 May 2001. (Same handed)

THE CHAIRMAN: This will be D17.

MR MORRIS: These are two chasing letters to the Council asking what is happening in relation to the complaints that have been lodged by the Commission. You will see on the left hand side various personnel, clearly part of the organisation of the Citizens Commission on Human Rights. You will see there under “Politics and Law” in relation to both letters – I am not going to say this in public – the name of somebody who was sitting on your Committee until he stood down from the Committee on the first day. I am not certain that those are one and the same person. I have not been able to make inquiries yet as to that fact. It certainly appears to be the same name. I do not know whether the qualifications match.

If it is the same name, and if that member of the Committee was correct in describing his relationship with the Scientologists, and I have absolutely no reason to doubt what he is saying is correct, then this appearance of his name representing him to be active within the Citizens Commission on Human Rights is wholly false and wholly misrepresentative of his real position.
For all those reasons, I suggest that head of charge 6 has arisen out of a cruel manipulation by the organisation of Mr Daniels in particular, of Mrs D in the promulgation of this complaint. Unfortunately, it has been added by what I have to suggest is Mrs D’s own dishonest attempts before you to disguise the Commission and Mr Daniels’ role in the formulation of this complaint. That is a matter which I suggest, if you accept as probably right on the balance of probabilities, is such that it falls into that category where it can be said that no right thinking person would approve of this Committee proceeding to inquire in relation to that complaint, given the fraudulent background to it.

Those are my submissions on head of charge 6. The question then arises, if you accept on the balance of probabilities that it would be an abuse to proceed to inquiry into that head of charge, what effect, if any, does that complaint have, or did it have on the decision to proceed with the other charges that were formulated in the letter of 1 October 2002?

As I conceded last week, there was nothing explicit on the face of the documentation that was disclosed to me by the Council and the Council’s Solicitors to suggest any causal link between the decision to proceed with the matters which, on any view, had been dormant for a considerable period of time in October 2002. What I do say is that a significant index of suspicion is raised by a number of factors.

First, the delay of 21 months by the Council in responding to the inquiry made by the Medical Protection Society, Dr Cosgrove’s defence organisation, about the identity of Mrs D. Secondly, a press release issued by the Commission before any decision had been taken by the Council to issue the rule 6 letter on 1 October 2002. Thirdly, the breach of promise or denial of legitimate expectation that the complaints or informations either would not be proceeded with at all or would be dealt with under the performance procedures. Fourthly, the refusal to give relevant disclosure by the Council.

Can I turn to those in turn? First, the delay of 21 months in the Council responding to the inquiry. You should have the inquiry and the response. (Same handed). The first is a letter of 25 January 2001.

THE CHAIRMAN: Shall we make that D18 and the second one D19?

MR MORRIS: The first letter was addressed by Dr Gerard Panting of the MPS to the Council on 25 January 2001.

“You may remember I telephoned you about this case in the middle of December.”

That would be December 2000.

“The concern here is that the complainant is not who she purports to be.

During our telephone conversation you said you would discuss this internally with the caseworker involved and revert to me.

Dr Cosgrove has had a further communication with the caseworker and has also
spoken to her over the telephone.

The concerns in this case are real in that the signature of the complainant does not match the signature in previous correspondence and the spelling of the surname has also changed.

Dr Cosgrove argues (in my view, reasonably) that it is essential that we are certain of the identity of the complainant to avoid inadvertent disclosure of this information.

I look forward to hearing from you in due course.”

The reply was not given to that until after the issue of the Rule 6 letter in October 2002 – 9 October 2002, in which a different case worker says:

“You refer to a letter which you sent to Mr Phillips’ predecessor on 25 January 2002.”

That, I suggest, is a mistake and it was a reference to the letter of 25 January 2001.

“I am sorry that due to an oversight we did not respond to your queries about the identity of Mrs D. It appears that our enquiries in relation to this were not communicated to you. I now enclose for your information a copy of a letter from Mrs D enclosing a copy of her driving licence. I enclose a further letter from Mrs D to us dated 11 December 2001.”

Sir, I think you have those letters in your existing exhibits. So, there was a 21 month delay by the Council in relation to what, on all accounts, was an important enquiry.

Secondly, the press release, which was published issued by the Commission before the issue of the Rule 6 letter. If I can hand that up. (Produced) Sir, perhaps the first in time should be the press release which is headed, “Psychiatrist under Scrutiny for Prescribing Practices.”

THE CHAIRMAN: We will make that D20 and the newspaper cutting D21.

MR MORRIS: The press release is what formed the basis of the article in the Bath Chronicle dated Friday September 20 2002. You will recall that was before the date when the Council’s solicitors formally wrote to the Registrar on 26 September and before the Rule 6 letter dated 1 October 2002. The press release from the Commission displays a remarkable knowledge about the state of affairs at the Council in relation to Dr Cosgrove, which goes beyond their own complaint:

“A batch of complaints on Bath-based psychiatrist Patrick Cosgrove may soon be the subject of a General Medical Council (GMC) inquiry into his practice. Complaints from all quarters of the medical profession, as well as patients, have been lodged with the GMC about Dr Cosgrove, who runs his private practice from the Bristol Priority Clinic, Bath. Both his conduct and his performance have come under scrutiny and the case is currently at the screening stage with the GMC.”
That found its way into print in the Bath Chronicle:

“A psychiatrist whose work with children has been criticised could face an investigation.

The Citizens Commission on Human Rights (CCHR) claims complaints about Dr Patrick Cosgrove’s conduct and performance have been lodged with the General Medical Council”

and the article goes on.

The third pointer which raises the index of suspicion as to the effect of Head of Charge 6 is what I have already outlined, I suggest, as a breach of promise or the denial of a legitimate expectation as to the way various complaints were going to be dealt with by the Council. Either there was a legitimate expectation that they would not be proceeded with at all or, there was a promise that they would be dealt with under the Performance procedures.

I am going to take you now through what information I have available to me for setting out the basis on which I make those submissions. I need to hand you, please, a bundle of documentation. (Produced)

THE CHAIRMAN: This is D22.

MR MORRIS: I think it would be most appropriate and it would make sense – or help to make sense, perhaps of my submissions – if I just took you through this documentation and why I say it is relevant.

The first letter – and I hope it goes in chronological order – dated 2 May 2001, is addressed to Dr Cosgrove and comes from the Fitness to Practise Department and relates to the complaint that was received from Dr Chubb. We are dealing here with Head of Charge 9, which formulates the allegations based on that complaint in that paragraph and relates to a letter sent by the doctor on 17 November 2000. It tells Dr Cosgrove what has happened:

“My colleague wrote to you on 12 February 2001 informing you about a complaint we received about you from Dr Helen Chubb, Cardiff and Vale NHS Trust.

Your complaint has been considered by both a medical and non-medical member of the GMC. They are appointed to decide whether the GMC should take forward complaints about the conduct and performance of doctors. This letter conveys their decision.

The members were concerned about the allegations made against you and have therefore made a decision to refer this matter for consideration under our performance procedures.

The file on this complaint has now been transferred to the performance team and
you will hear from them in due course.”

Over the page a letter later on that month relating to a complaint received from Pembrokeshire and Derwen NHS Trust. That relates to patient B at Head of Charge 3.

MR PEARCE: May I interject. I am sorry to interrupt. I am not at all clear this is being suggested that this is those matters contained in that charge. If that is about to be suggested, I do not think that that is correct. I just make that point in advance of the submission.

MR MORRIS: I need time to check that, if that suggestion has been raised. Sir, I think it is important I get that right and I would not wish to proceed if that is wrong, obviously, in relation to that particular matter. I am not sure when you were considering taking a break this morning. I wonder if this might be an appropriate time.

THE CHAIRMAN: I suspect you still have quite a bit to go so that I think this might very well be a convenient time to have a break and we will reconvene around 11.15.

The Committee adjourned for a short time

MR MORRIS: Sir, I have spoken with Mr Pearce and I think he accepts now that the letter written by the Council on 24 May 2001 in relation to a complaint made by the Pembrokeshire and Derwen NHS Trust, is the same complaint that features in Head of Charge 3, which deals with the letter written by Dr Cosgrove on 3 December 1999 to the patient’s GP, with a copy to Dr Al-Shabnder and the remarks made about Dr Al-Shabnder in that letter.

MR PEARCE: Yes, sir.

MR MORRIS: Again, this was as letter of 24 May that conveyed the decision of the two screeners, the medical and non-medical. It sets out their powers and then says:

“In this case the members do not consider that the information received from Pembrokeshire & Derwen NHS Trust warrants further consideration under the conduct procedures. However, they remain concerned about the number of complaints they have received about your conduct. In view of this they have decided to review this matter for further consideration under the GMC performance procedures.

This file will be passed to our performance section who will be in contact in due course.”

That was May 2001 and we then skip a long period of time and there is incomplete documentation here in my submission to tell the whole story. We skip to a memorandum written by Dr Malcolm Lewis, a medical screener, dated either 24 or 29 February 2002.

It is headed “This is a screening memo that can be copied into the following four cases against Dr Cosgrove.” It should follow on the letter of 24 May.
"I have considered the following cases of complaint against Dr Cosgrove"

and then various file references are set out there.

"1. It is my view that the nature of these complaints in the circumstances of Dr Cosgrove’s practice could not amount to seriously deficient performance. There is a pattern of poor practice but the issues relating to prescribing would be impossible to prove either way.

2. In particular I feel the most important practice on which this case must proceed relate to issues of potentially serious professional misconduct in view of two repeated themes in the various cases. I have highlighted these with purple tabs in most of the files.

3. The Citizens Commission under Human Rights v P Cosgrove 200/1711. There is a complaint of inadequate monitoring with lack of a developed protocol and lack of evidence of shared care and advice to any general practitioners.

4. 2000/2124 (as above also relates to Master D)

5. Dr Kurnar v Dr Cosgrove – 2000/0040. This represents the second theme developed from the complaints, that is of inappropriate or disparaging remarks regarding medical colleagues. There is also a lack of evidence of any advice or agreement of monitoring of this child through a shared care protocol. These matters would raise issues of potential SPM"

Can I say at this stage, sir, I think it will appear in later correspondence that that case was closed and no action taken against Dr Cosgrove on it.

"6. Pembrokeshire Trust v Cosgrove – 2000/0871. Issues raised suggest inappropriate comments, disparagement raising issues of potential SPM.

7. In this case the doctor has been previously informed that this case would not proceed under the conduct procedures. However, cases that have come to light since would enable this case to be resurrected under the appropriate clause.”

Sir, that is a refrain that you will see further in further documentation. May I say at the very outset that in my submission there is no evidence disclosed here or available to the defence to suggest that there were subsequent cases to the decision to refer to performance, which was communicated in May 2001. There was nothing that post-dated that that could have caused or given good grounds for re-visiting that decision as was done by this screener in February 2002 or, indeed, subsequent to his letter of February 2002 and running up through to 1 October 2002 when the Rule 6 letter was issued.
“8. Cardiff and Vale NHS Trust v Cosgrove – 2000/3359. No advice regarding monitoring or shared care protocols with a general practitioner, potential SPM.

9. Moses v Cosgrove – 2000/1390. I think this may be the same one as the Pembrokeshire and Derwen Trust. There are tabs in the page and what I would like to say is breach of professional confidence, the letter from Dr Moses to Dr Cosgrove was primarily about Dr Cosgrove and not his patient. It should have been afforded the confidentiality that Dr Moses clearly requested in her headed paper. Also disparagement, there is a general suggestion that a sub standard level of care was being delivered at the NHS Trust and finally no advice or instruction regarding appropriate monitoring by the GP responsible for prescribing, that is no shared care protocol.

10. 1997/1376. Quite a big file, I have stuck a tab in it behind tab 11 which was an original draft Rule 6 letter which came to nothing in the end. I think we conceded to his rebuttal by the look of it.”

This, sir, I think it would be agreed is dealing with Head of charge 2, Patient A.

“Anyway, I think under head 3”

- that is presumably clearly a reference to the draft Rule 6 letter –

“if you add…”

and various additions are suggested.

That was the screener’s view on February 2002. It came after earlier screening of the complaints by another medical screener and a lay member.

Running through what was disclosed chronologically, we then turn to a memorandum – an internal GMC memorandum dated 28 May 2002, between staff at the Council. I am not quite sure of their status but they must be case workers or more senior, in my submission.

Dr Moses’ complaint against Dr Cosgrove, you asked for a brief summary. I am providing only a brief summary at this stage as it is one of six current cases involving Dr Cosgrove which I have recently inherited. I am also aware of an imminent joint referral by a Health Authority in Wales and the Home office Drugs Inspectorate.

Background

In recent years we have received a number of complaints and concerns about Dr Cosgrove’s activities. He is a private doctor who specialises in treating children diagnosed as suffering from Attention Deficit Hyperactivity”, and goes on to give a background of the sort of complaints being made about him:
"3. Dr Cosgrove has robustly defended all complaints against him, often with the support of parents who consider that their children have benefited from treatment with Ritalin. In the past screeners have concluded that Dr Cosgrove has acted on the fringes of acceptable practice and complaints against him have been closed.

However in January 2001 a screener referred a number of complaints and referrals to the Performance Procedures. Dr Cosgrove was informed of this decision.

In February 2002 a number of the cases were re-screened by a different screener. He decided that they should be dealt with under the Conduct procedures. The screener identified ..." (and that is clearly a reference to Dr Malcolm Lewis' memorandum) "... two main potential SPM themes as being the lack of a developed protocol or proper consultation with other practitioners when treating patients and making inappropriate and disparaging remarks about medical colleagues. (As I understand it, Dr Cosgrove has not been told about this change of decision)",

and it then goes on to deal with Dr Moses' complaints:

"Next steps

9. The Cosgrove case is both complex and sensitive. I need to assess all cases to see if they have been dealt with according to our procedures and to seek legal advice about the latest screening decision. I will also need to deal with the impending referral from Wales which I understand will include allegations of irresponsible prescribing and may include the strongest evidence to date of possible serious professional misconduct on the part of Dr Cosgrove".

Sir, may I just say at that stage - and I shall be corrected if I am wrong - that again my submission is that there is no evidence that there was a referral from Wales subsequent to the decision to go down the Performance route and prior to the issue of the Rule 6 letter on 1 October 2002.

There is then a memorandum from the same staff member, Ann O'Sullivan, to Peter Steel a solicitor to the General Medical Council:

"I am referring to you 10 open cases against Dr Cosgrove for legal advice on a couple of points and a request that you consider draft charges for the screener to consider for referral to PPC."
Background

Please refer to the briefing note I prepared for Christine Couchman "(I think that is the previous memorandum) "... which provides a very brief summary of the background to these cases and the issues we need ... I have also prepared a table which summarises the stage we have reached with each case (flag B)".

And if you look on, sir, you will see that table set out under the heading "Cosgrove open cases list" - two pages of table. We will come to that in due course, but the memorandum continues:

"As my note to Christine explains and the table shows, a screening decision was made that the concerns about Dr Cosgrove should be dealt with under the Performance Procedures. This decision was communicated to Dr Cosgrove in May last year, although no further action was taken and, as far as I can see, there has been no further communication with Dr Cosgrove on this.

However, since then, the cases have been reviewed by another medical screener who considered that the cases raised issues of SPM and not SDP. There is no memo. to the Screener and I understand that Dr Lewis came into the office to review the files.

I now wish to refer the cases formally to a screener with draft charges for referral to the PPC. Before doing so however, I should be grateful for your view on whether there will be any difficulties with changing track on how we propose to deal with the cases. In my view we can argue that the complexion of the case has changed since further information has been received from the police - information which suggests irresponsible prescribing. This information was received very recently and has not yet been seen by a screener".

Again, in my submission, there is no evidence of that that postdates the re-screening or predates the re-screening by Dr Lewis, or indeed postdates his re-screening in February 2002 and before the Rule 6 letter of 1 October 2002.

And then we have the open cases list, which I will come to if I may when I deal with each of the Heads of Charges that are before you and indeed were listed in the Rule 6 letter.

If we go on then to the response from Mr Steel, 30 August 2002, to Peter Lynn of the GMC re Dr Cosgrove:

"Thank you for your instructions to advise on these
complicated and long-running matters. We have of course spoken about them but here is a short summary with my advice;

1. Performance/Conduct?

It appears that the files were reviewed by Malcolm Lewis 27 February 2002 who screened them all down the Conduct route (I see his note of even date) despite the fact that some had already been screened down the Performance route and Dr Cosgrove had been informed that this was the case. I have discussed this with Paul who is of the view that on policy grounds alone we cannot go behind this decision, regardless of whether it was correct in law to do so. It may in fact have been legitimate for the screener to say that in the light of the further complaints this case was better dealt with down the Conduct route, but that is perhaps an academic debate",

a view I do not share on behalf of Dr Cosgrove:

"I enclose the draft charge, which is the best I can do with the information available. I have drafted this in the second person - you may wish to change it...", etc.

And the final document, 16 August -- no, I am sorry. I have got out of sync. chronologically. This should come before the 30 August memo. and I apologise. It is again from the solicitor to Peter Lynn:

"I think you discussed this doctor Ann O'Sullivan, who went off on sick leave earlier this week",

and reference is made to the memo. to Christine Couchman dated 28 May. I think that was one of the earlier memoranda. Yes, it was one of the earlier memoranda. It then refers to the table:

"Ann's table had seven cases on it, but there are three additional cases ... The later two are complaints received from Dr Cosgrove. I am sorry that Ann went off on sick leave before completing the table and finalising her memo. However, I hope there is here enough for you to form a preliminary view. I am sorry to burden you with ten files ..."

Paragraph 4:

"For my part, I would suggest the suggestion by Ann that although there was an initial screening decision to refer some matters into performance, it should be open to the
Council to decide that the complexion of the case has changed because of further information, outlining serious issues, that has continued to arrive.

I should add that although Ann mentioned PPC in her Paragraph 6, we should not exclude performance action, depending on your advice, and a further consultation with Dr Lewis. However, he clearly felt that this case was now in the realms of misconduct rather than deficient performance”.

And again, sir, I submit, or I say, that in relation to the suggestion about "... further information outlining serious issues..." there has been nothing disclosed to the Defence and there is nothing that appears in the Rule 6 letter that suggests that any information - further information - about Dr Cosgrove arrived subsequent to the decision to send this case down the Performance route.

THE CHAIRMAN: I am sorry, did you say the Conduct route?

MR MORRIS: No, the first decision taken to send it down the Performance route.

THE CHAIRMAN: Oh, I am sorry. Yes, I follow what you are saying. Thank you.

MR MORRIS: Can I turn then to the Heads of Charge that you have before you, sir, and the first one Head of Charge 2 dealing with Patient A. It might help if you have the table - the "Cosgrove open cases list" table - open and available to you.

This is the patient who was being cared for at one time by Dr Holme and he is the Complainant in relation to that case. Dr Holme, Salisbury Healthcare NHS Trust, and you will see that in the first box for 1997. And you have got there, taking you across the top, the identification of the Complainant, or the referrer. Well, it is the case reference first of all and then the Complainant or referrer. It is then the date the case was opened, which would appear in each case to be very shortly after receiving the written complaint; then the nature of the case; whether the complaint had been disclosed to the doctor; the decision and the date when the decision was taken first by the Medical Screener and secondly by the Lay Screener and whether or not the Lay Screener agreed with the Medical Screener and the date of the Lay Screener's decision; whether or not then, in the next column, the decision was notified to the doctor and the date upon which it was notified; and then a final column "Rescreened as conduct? Any other comments?"

In relation to that first complaint then, Head of Charge 2, Patient A, Dr Holme, there are two entries in that box under the same case reference "1376" - "04" and "06" - and there is a reference to "HO", presumably Home Office, Drugs Inspectorate. That was a case opened on 1 October 1998, although it appears that the information was received on the 22nd -- 22 July 1999 in my submission relates to the date of the Complainant's letter - Dr Holme's letter.

The Home Office Drugs Inspectorate referral is, in my submission, a case that was closed and no action has been taken against the Doctor. It certainly did not appear in the Rule 6
letter and it does not appear in the charges before you. And, importantly, in any event it predates the decisions of the first Screener which were taken towards the end of 2000 and the beginning of 2001 in relation to all the other complaints.

In relation to the Dr Holme complaint, though, at Paragraph 2 in that box, dealing with the chronology of it, the complaint was received from Dr Holme on 22 July 1999. Professor Taylor, you will see in the final box where it is mentioned that, "There is an expert report by Professor Taylor re matters raised at /04 and /06". Professor Taylor's report I can tell the Committee is dated 22 October 1999 and Dr Cosgrove was informed of the existence of the complaint from Dr Holme on 18 November 1999 and you can see that in the relevant column.

Dr Cosgrove responded to that complaint on 6 December 1999. It does not appear in the table there, but it is clear on documents disclosed earlier that there was such a response or rebuttal. And, sir, that is a reference to -- that is referred to in Dr Lewis' memorandum about this Head of Charge or complaint.

You can see at Paragraph 10 of his memorandum the reference "197/1376", which is the reference we are dealing with now, where he said:

"There was an original draft Rule 6 letter which came to nothing in the end. I think we conceded to his rebuttal by the look of it",

and that in my submission is a reference to Dr Cosgrove's rebuttal, but then he makes proposals for amending that draft Rule 6 letter.

Now in relation to this complaint, although the Doctor was informed about it on 18th November 1999, he received no formal response from the Council until the Rule 6 letter of 1 October 2002; nearly three years from the date when Dr Cosgrove was informed of the existence of the complaint.

The Medical Screener's decision of 16 August 2000 and 31st August 2000 has not been disclosed despite a request by the Defence. In my submission, that would be a relevant disclosure and it might cast light on what happened to the case and why it came to nothing and no action was taken until the Rule 6 letter.

But this case falls in my submission into the category -- and perhaps I should have prefaced my remarks by saying there are two categories of case here, in my submission. Those where the Doctor was given a legitimate expectation, or is entitled to a legitimate expectation, that the cases would not be proceeded with, and the second category is those where he was given a promise that they would be dealt with under the Performance procedures.

I say that that legitimate expectation arose, sir, and it arose for the reason that he was told nothing and was given no information as to what had happened to that complaint during the three-year period that elapsed from being told about the existence of that complaint to the Rule 6 letter on 1 October 2002.
The second Head of Charge that comes into that category is in fact Head of Charge 6, Patient D. You will see that on the open cases list at the bottom of the first page under reference "2000/1711 Complainant Citizens Commission on Human Rights", and that runs over. I think it should read "about" and then there are two names there, one of which is Mrs D.

The first complaint that was made by the Commission was dated 28 June, sir, and you in fact now have that at D12.

There was a further complaint dated 2 October 2000 which I do not believe you have. (Pause) Sir, I can tell you that if you do not have documentation about I do not propose to give it to you, but it was a complaint about a report in a newspaper in which Dr Cosgrove is reported as describing his use of the drug Ritalin. That was complained about to the Council. I can tell the Council (sic) did not feature in the rule 6 letter and it does not feature in the complaint under head of charge 6. Again, importantly, it predates the first screener’s view of cases in 2001 or late 2000.

Although it is stated that it is not clear whether Dr Cosgrove was made aware of those complaints, he clearly was made aware of those complaints, because we have the letter written by Dr Gerard Panting of the MPS at D18 on 25 January 2001, where he mentions talking to the GMC in the middle of December, so some time before December 2000 we know that the doctor was made aware of that complaint.

Thereafter, nothing was communicated formally to Dr Cosgrove until the rule 6 letter of 1 October 2002, in other words for at least 21 months, during which time there was complete failure to respond to Dr Panting’s letter of January 2001. Again, in my submission, that lapse of time gave rise to a legitimate expectation in the mind of Dr Cosgrove that nothing further would be done in terms of GMC action in relation to that case.

Finally, in this category is head of charge 4, patient C, which is information sent by Dr Moses. You will see that on the second page of the table under the reference 2000/1390, Dr Moses of Gwent Health Care NHS Trust. Information was sent by her, I can tell the Committee, in a letter dated 2 August 1999, although it appears that the case was not opened until 6 June 2000. The nature of the complaint is set out in the next column. Y indicates that the doctor was informed about the complaint on 9 August 2000. The medical screener’s decision was made on 19 January 2001 and was that the case – and in my submission the letters SDP must stand for seriously deficient performance – was a decision, one can infer, that the case should be referred to the performance procedures of the GMC. That was ratified by the lay screener on 1 February 2001. The defence have asked for and have been refused access to those screener’s memoranda.

Significantly, though, it appears that the doctor was not informed about that decision. You see the “no” in the next column, and so again this is a case where, having been told about the complaint’s existence on 9 August 2000, the doctor heard nothing more until 1 October 2002, that is two years and two months later when he received the rule 6 letter. Again, in my submission, because of that period of time a legitimate expectation arose in Dr Cosgrove’s mind that he would not be proceeded with, because of the absence of any information about that matter.
That is the first category. The second category is where the doctor was specifically told that these matters were going to be dealt with under the performance procedures. The first of those is head of charge 3, which is the letter about Dr Al-Shabner. It is the Pembrokeshire and Derwen NHS Trust. You will see it on the first page of the table under reference 2000/0871. The complaint letter is dated, I can tell the Committee, 23 March 2000, although the case is opened on 1 April. The nature of the letter is made clear. It was disclosed to the doctor on 7 August 2000. The medical screener saw it on 8 November 2000 and determined that it should be referred to performance. That was ratified by the lay member on 29 January 2001. That decision was disclosed to the doctor on 24 May 2001 and you see that second letter in your bundle at D22, where it is said that the members, that is the two screeners, do not consider the information received from the Trust warrants further consideration under the conduct procedures. They have decided to refer the matter for further consideration under the GMC performance procedures. Again, those original screeners’ memoranda of November 2000 and January 2001 had been requested, but their disclosure has not been granted to the defence.

In my submission, therefore, that letter sets up not only a legitimate expectation that the matter would be dealt with under the performance procedures. It effectively amounted to a promise that that was what would happen to that complaint.

The next head of charge is 7, which is patient E. That is the Oxfordshire Mental Health Care NHS Trust. The complainant was Miss Wendy Samways. You will see the reference to that in open cases table at 2000/3017, three down on the first page. The complaint letter itself is dated 23 October 2000. The case was opened on 3 November 2000. The nature of the complaint is made clear. It went to the medical screener on 24 May 2001. I am sorry. It was disclosed to Dr Cosgrove on that date. It had been before the medical screener on 15 February 2001, who had decided that it should go down the performance route. That was ratified by the lay screener on 26 February.

The doctor was notified about that on 24 May. That is the first letter. No, it is not. You do not have the letter notifying the doctor about that. Unfortunately, the doctor does not still have it in his possession. I have asked for disclosure of that. I do not think there is any objection taken by the Council for disclosure of that letter, but it does not appear to have been found as yet. Clearly, according to this memorandum and this table, the doctor was told about the decision that his case or the complaint from Oxfordshire Mental Health Care Trust should go down the performance route.

Finally, head of charge 9, patient F. This is Cardiff and Vale NHS Trust. That you see on the second page of the table under the reference 2000/33. The complaint from Dr Chubb was dated 28 November 2000. The case was opened on 12 December. The nature of the complaint is set out there. It was disclosed to the doctor on 12 February 2001. Again, it was screened on 23 March 2001. The decision was taken to go down the performance route. It does not appear to have been or there is no evidence that it was referred to or seen by a lay screener, although it must have been so done, in my submission, before a letter was sent out on 2 May 2001 telling the doctor of the decision. We can see that letter. It is the first document in that bundle. It states, “Your complaint has been considered by both the medical and non-medical
member of the GMC.”

If that letter is correct, that entry in the box “no” under lay screener seems to be an error. The decision of the two screeners was,

“They were concerned about the allegations made against you and therefore made a decision to refer to this matter for consideration under our performance procedures.”

In very lengthy exposition those are the matters that come under the third category of matters that raise the index of suspicion as to the possible effect of head of charge 6, if you find that was probably a fraudulently promulgated charge.

The fourth heading whereby the index of suspicion has been raised is the lack of disclosure. The Council, as from Friday afternoon, are now declining to give any disclosure in relation to matters about which help or assistance was sought by the defence, in particular, in relation to the original screener’s decision memoranda, both medical and lay, where on the one hand we have disclosed to us the subsequent screener’s decision, Dr Malcolm Lewis, but we are deprived of the original decisions suggesting that this case was a performance case and making that decision.

We have not been given any disclosure as to what happened once these cases went to performance. We have not been given any disclosure as to the circumstances that led to and the reasons for these matters being re-screened by Dr Lewis in February 2002. Those matters that were re-screened were patient B, patient C, patient E and patient F.

That material, in my submission, would be highly relevant and may well assist the defence and undermine the Council in promulgating this abuse of process argument, both in relation to the effect of head of charge 6 and also in relation to the separate free standing submission that there has been a breach of promise or a thwarting of legitimate expectation as a separate head of abuse, apart from the fact that it would also, in my submission, be relevant material in terms of dealing with the substance, if we get to that stage, of the particular cases and allegations made, because obviously if a screener has taken the view and given reasons as to why these matters should not come under the heading of conduct, those reasons might well give avenues for the doctor to explore with his legal team, which currently they do not know.

Those are the indices of suspicion which are raised on the material that you now have before you and the defence now have as to whether or not Head of Charge 6, if improperly brought, has had a knock-on effect in relation to the other Heads of Charge.

In my submission those indices can help you to come to the conclusion on the balance of probabilities that they have corrupted those remaining Heads of Charges and that those remaining Heads of Charges, therefore, ought to be stayed as a result of those matters flowing from Head of Charge 6.

Can I just deal with the last two complaints which post-dated the Rule 6 letter of 1 October 2002 and those are Heads of Charge 10 and 11 dealing with patients G and H. Obviously I cannot submit that Head of Charge 6 had any effect on those two charges,
because obviously they post-date it. What I do say, though, is that if as a result of Head of Charge 6 the earlier matters have all gone to conduct whereas otherwise they would have remained in performance and/or perhaps not been dealt with at all, then in my submission it is quite probable that these two further complaints when they came in would have been sent down that same route and not have been referred as conduct matters. They are of a similar nature to the earlier six matters.

Can I turn finally to the breach of promise point which, even if you do not accept that as one of the indices of suspicion does not help in relation to Head of Charge 6 and the effect that has on the remaining charges, even if you reject that, in my submission there is a free-standing abuse here in relation to breaches of promise and the thwarting of the legitimate expectation that I have set out to you.

I need to justify that legally and I wonder if I can assist the Legal Assessor in that regard by taking him to paragraph 462 of Archbold. I believe he has now got an up-to-date edition.

The sub-heading here is, “Prosecution going back on promise” etc. It comes as one of a number of headings under the major heading, under Abuse of Process at 448 it comes under the general heading of “Application of the Principles”, that is sub-paragraph D to be found at the top of page 336 in paragraph 457.

MR MORRIS: Exactly. It is one of the sub-headings under “Application of the Principles” and under “Misuse and Manipulation etc Process of Court and Unfairness”, we come to, “Prosecution going back on promise”. What the editors say there is that:

“The prosecution of a person who in exchange for his co-operation has received an undertaking, promise or representation from the police that he would not be charged with an offence, is capable of amounting to an abuse of process. It is not necessary for the applicant to show that the police had the power to make the decision not to prosecute, nor is it necessary for him to show that the case was one of bad faith.”

The leading case cited there is the one of R v Croydon Justices, ex parte Dean, a copy of which I think the Legal Assessor has. That is a Divisional Court case of 1993. Perhaps I can just read the headnote to that case and take you and the Committee — I think it would be unfair to the Committee if they did not have the case as well, so can I hand round copies of the case. (Produced)

THE CHAIRMAN: That will be D23.

MR MORRIS: The facts are set out in the headnote:

“"The applicant, aged 17, and two other men, G and B, were arrested by the police in respect of a murder investigation. The applicant did not take part in the killing but after it had taken place he assisted in destroying the victim’s car. When interviewed by the police he made statements..."
containing potentially important evidence against G. The applicant agreed to be a prosecution witness and by the time he had left the police station he had in effect admitted doing acts with intent to impede the apprehension of G and B, but was not then charged. The same evening, G and B were charged with murder. Five days later the applicant again went to the police station where he admitted for the first time that G and B had driven him to the scene of the crime and shown him the victim’s body. At the end of the interview he was informed that he was a prosecution witness and had the protection of the police. He later went with the police to the scene of the crime and described how the victim’s car had been destroyed. Thereafter, the Crown Prosecution Service decided, after a conference with the police, that the applicant should be charged under section 4(1) of the Criminal Law Act 1967 with assisting in the destruction of the victim’s car, knowing that it was evidence, with the intent to impede the apprehension or prosecution of G and B, knowing or believing that they were guilty of murder or some other arrestable offence. Before he was charged, the applicant made further statements to the police identifying articles belonging to G and B which he had seen in the victim’s car. He was then charged. At the committal proceedings the justices rejected a submission that they should not act as examining justices to inquire into the offence on the ground that it would be an abuse of process and also refused to adjourn the proceedings pending an application to the High Court for a stay. The applicant was committed for trial and applied for judicial review of the justices’ decision and the committal. On the question whether judicial review proceedings were appropriate, and, if so, had there been an abuse of process”

and there were rulings. Can I take you to the second ruling, really, which concerns us, which is in relation to abuse of process. Under the heading over the page:

“(2) The prosecution of a person who had received a promise, undertaking or representation from the police that he would not be prosecuted was capable of being an abuse of process. On the undisputed evidence in the instant case the applicant was given to understand for a considerable time that he was to be a prosecution witness, from which it almost certainly followed that he was not himself to be prosecuted for any offence in connection with the murder; but that undisputed evidence did not show that he received any express promise, undertaking or offer of immunity; nevertheless in the quite exceptional circumstances of the case, having regard to the applicant’s age at the time, the assistance he gave to the police for over five weeks, it was clearly an abuse of process for him to be prosecuted subsequently. Accordingly, the application would be granted.”

In the heart of the Judgment given by Lord Justice Staughton at page 82, under the heading Abuse of Process, he says half way down that passage:

“We were referred to three cases which suggest that abuse of process in
this context can only exist where there is (i) delay, or (ii) manipulation or misuse of the rules of procedure”

and authorities were cited there. The Lord Justice went on to say:

“But there is high authority that the concept is wider than that. In Hunter v Chief Constable of the West Midlands Police [1982] Lord Diplock spoke of:

‘the inherent power which any court of justice must possess to prevent misuse of its procedure in a way which, although not inconsistent with the literal application of its procedural rules, would nevertheless be manifestly unfair to a party to litigation before it, or would otherwise bring the administration of justice into disrepute among right-thinking people. The circumstances in which abuse of process can arise are very varied…”

Then Lord Devlin in Connelly is cited:

‘Are the courts to rely on the Executive to protect their process from abuse? Have they not themselves an inescapable duty to secure fair treatment for those who come or are brought before them? To questions of this sort there is only one possible answer.’

His final settled Judgment over the page at 83, just above the conclusion:

“In my judgment the prosecution of a person who has received a promise, undertaking or representation from the police that he will not be prosecuted is capable of being an abuse of process. Mr Collins was eventually disposed to concede as much provided (i) that the promisor had power to decide and, (ii) that the case was one of bad faith or something akin to that. I do not accept that either of those requirements is essential.”

In his conclusion he went to apply those principles to the facts of that particular case and decide that the proceedings would have to be quashed as an abuse.

The editors of Archbold continue at 462:

“Breach of a promise not to prosecute does not necessarily and ipso facto give rise to abuse but the longer that a person is left to believe that he will not be prosecuted”

- and I rely on that –

“the more unjust it becomes for the prosecution to renge on its promise that any manifest prejudice to him resulting from his co-operation will make it inherently unfair to proceed”
and there is a reference to *R v Townsend 1997*. In a Privy Council case, *The Attorney General of Trinidad and Tobago v Phillip 1995*, it was said that:

> “It could well be an abuse of process to seek to prosecute those who have relied on an offer or promise of a pardon and complied to the conditions subject to which that offer was made, even though the path was invalid.”

They go on:

> “Where a defendant had received a letter constituting a ‘final decision not to prosecute’ in respect of an allegation of sexual offences against a ten-year old boy, the reinstitution of proceedings many years later could not be justified by reference to the fact that a second boy had more recently made a complaint, nor by reference to the fact that the original decision had been taken in the light of the then rule of evidence requiring corroboration. The prosecution should have been stayed as an abuse and the conviction was quashed as unsafe on account of the prejudice arising from the non-availability of various materials from the original investigation.”

That is the case of *R v D* reported in Archbold News in the year 2000.

There is then a case called *R v Bloomfield* – copies again I would like to give to the Committee.

**THE CHAIRMAN:** This will be D24. *(Produced)*

**MR MORRIS:** If I can read you the headnote. This is a Court of Appeal decision in 1996:

> “The defendant was charged with possession of a Class A controlled drug. At a plea and directions hearing at the Crown Court prosecuting counsel indicated to defence counsel that the Crown wished to offer no evidence because it was accepted that the defendant had been the victim of a set-up. Owing to the presence in court of certain people it would have been embarrassing to the police and prosecution if no evidence were offered that day so counsel spoke to the trial judge in his room. An order was then made in open court to adjourn the case and relist it ‘for mention’. The Crown Prosecution Service subsequently arranged a conference with new prosecuting counsel and thereafter informed the defence solicitors that the Crown intended to continue the prosecution. An application at the trial to stay the proceedings as an abuse of process having failed, the defendant pleaded guilty and was sentenced to three months’ imprisonment. On appeal against conviction on the question (1) whether it was an abuse of process for the Crown to revoke a previous decision, communicated to the defendant and the court, to offer no evidence and, if it could be an abuse of process, whether (2) it made any difference if prosecuting counsel had made that decision and
communicated it to the defendant and the court without authority.”

The appeal was allowed:

(1) that whether or not there was prejudice to the defendant, it would bring the administration of justice into disrepute to allow the Crown to revoke its original decision without any reason being given as to what was wrong with it, particularly as it was made coram judice in the presence of the judge; and

(2) that neither the court nor the defendant could be expected to enquire whether the prosecuting counsel had authority to conduct a case in court in any particular way and they were therefore entitled to assume in ordinary circumstances that counsel did have such authority.

On the final page of Lord Justice Staughton’s judgment he sets out his conclusions, page 143:

“Looking at the case in the round, it seems to us that this is an unusual and special situation. The decision to defer the trial on December 20 was taken for the benefit of the prosecution in order that they would not be embarrassed when it was said in court that no evidence was being offered. The statement of the prosecution that they would offer no evidence at the next hearing was not merely a statement made to the defendant or to his legal representative. It was made coram judice, in the presence of the judge. It seems to us that whether or not there was a prejudice it would bring the administration of justice into disrepute if the Crown Prosecution Service were able to treat the court as if it were at its beck and call, free to tell it one day that it was not going to prosecute and another day that it was.

Of course the circumstances of each case have to be looked at carefully, and many other factors considered. As the Court said in the Mahdi decision, we are not seeking to establish any precedent or any general principle in regard to abuse of process. We simply find that in the exceptional circumstances of this case an injustice was done to this appellant. In those circumstances the appropriate course is to allow the appeal and quash this conviction.”

Sir, in my submission those cases and the guidance given by the editors of Archbold are wholly appropriate to what has happened in this case. The analogy is valid, that you have here on the one hand a promise - a clear indication - that the cases are going to be dealt with by Performance, and on another you have through lapse of time - that in one case extended, I think, to three years - a legitimate expectation that nothing further was going to happen in relation to complaints made against the Doctor.

There is no evidence certainly not disclosed to me, or the Defence, or in the Rule 6 letter, or in the Heads of Charge, that there was any other complaint or material that came to the
attention of the Council that might begin to justify the Council going back on its promise, or revoking the expectation that had been allowed to grow in Dr Cosgrove's mind. For those reasons I submit that on its own, out with any concerns arising out of Head of Charge 6, certainly in relation to those cases covered by the breach of promise and the expectation or legitimate expectation, which is all the charges up until the Rule 6 letter but does not include the subsequent two charges -- in relation to those six charges in my submission it would be an abuse on this ground to allow those cases to proceed.

The third freestanding ground upon which I submit abuse is in relation to the failure of the Council to make proper disclosure. I have outlined the sort of disclosure that one could expect and the documentation that one could expect. It, in my submission, clearly or most probably exists. One can divine that from the bundle of documentation that has been disclosed - D22.

As to whether non-disclosure can amount to abuse, can I refer you to what I hope is a helpful passage and again there are copies for the Committee. I hope there are enough to go round.

THE CHAIRMAN: This will be D25.

(Copies of the document were distributed)

MR MORRIS: I think that the learned Legal Assessor should already have one.

THE LEGAL ASSESSOR: I have not got it with me, but I will give my copy back.

MR MORRIS: You have not got it with you, right. Let us see how we go then.

This is an extract from a textbook called "The Abuse of Process in Criminal Proceedings", by David Corker and David Young, and it is the second edition dated 2003. I am not going to take you through all of this, but the opening paragraphs under "Non-disclosure Abuse" are informative:

"It is trite law that an accused's right to fair disclosure is regarded as inseparable from his right to a fair trial. An accused must be in a position to fairly advance his arguments by way of fair disclosure of material in the Crown's possession. In R v Togher the Court of Appeal held that where an accused's right to a fair trial was vitiates, for example because of non-disclosure, this would almost invariably result in the quashing of the conviction. Woolf CJ held 'If they could establish an abuse, then this court would give very serious consideration to whether justice required the conviction to be set aside'.

Recent developments have underlined that the right to disclosure is regarded as a fundamental condition or hallmark of fairness. The Attorney-General's Guidelines on the disclosure of information in criminal proceedings were
introduced in an attempt to improve the operation of the current statutory disclosure regime”.

Those guidelines, for the assistance of the Legal Assessor, are set out in the first supplement to the 2004 Edition of Archbold at Paragraph A/242.

THE LEGAL ASSESSOR: Thank you.

MR MORRIS:

"The opening paragraph declares:

'Every accused person has a right to a fair trial, a right long embodied in our law and guarantee under article 6 of the European Convention on Human Rights. A fair trial is the proper object and expectation of all participants in the trial process. Fair disclosure to an accused is an inseparable part of a fair trial'.

These laudable words are followed up in para 5 of the guidelines, with an unequivocal warning to investigators and disclosure officers namely:

'A failure to take action leading to proper disclosure may result in a wrongful conviction. It may alternatively lead to a successful abuse of process argument or an acquittal against the weight of evidence’",

and it goes on to say why the guidelines were produced in that it was:

"... in response to concerns about the operation of the disclosure provisions in the Criminal Procedure and Investigations Act 1996 …"

And then over the page, under "The CPIA 1996; prosecution failures to comply with the service of 'primary' and/or 'secondary' disclosure", I do not want to get into the technical detail of that but what is clear is that the prosecution are under a duty to disclose any material that might be reasonably expected to assist the accused's defence and you can see that in the opening sentences of Paragraph 4.59. That is particularly the case where the line of defence has been identified by the Defendant, sir, as Dr Cosgrove has done in this particular case:

"Clearly those accused ..." (it goes on to say) "... who have set out their defences in interview, have served full defence case statements ... followed up by chasing letters to the prosecution in correspondence, are in the best position to maximise their disclosure opportunities".

And then under the heading "Examples of non-disclosure giving rise to abuse", I will not
"In R -v- Blackledge following pleas of guilty to breach of export controls concerning arms to Iraq, it transpired via the Scott Inquiry that exculpatory material had been withheld from the defence. This material, whilst not affording a defence to the offence charged, would have enabled the accused to mount a probably unassailable abuse application; that the exports of weapons had been secretly approved or deliberately overlooked by the DTI. The Court of Appeal promptly quashed the convictions of all accused on the grounds of non-disclosure."

And if I can then take the Committee to the impact of the European Convention of Human Rights and Article 6, under 4.68 and 4.69 there is cited there a case of Kaufman -v- Belgium:

"'everyone who is a party to ... proceedings should have a reasonable opportunity of presenting his case to the court under conditions which do not place him at a substantial disadvantage vis-à-vis his opponent'.

In Jespers -v- Belgium the Commission stated that the now enshrined 'equality of arms' principle imposes on prosecution and investigating authorities an obligation to disclose any material in their possession. The obligation is applicable to any material to which they could gain access which may assist the accused in exonerating himself. The duty is said to be necessary to remedy the inequality of resources between the prosecution and defence, and the principle applies equally to material which might undermine the credibility of a prosecution witness".

I ought for completion to go to 4.72:

"Whilst the European Court of Human Rights has made it clear in the Edwards -v- United Kingdom decision, and in a string of subsequent cases, that article 6 generally requires the prosecution to disclose to the defence all material evidence for or against an accused, nevertheless, it is also clear that the entitlement to disclosure of relevant evidence is not an absolute right. In Van Mechelen -v- Netherlands the court adopted a principle of 'strict necessity' in this regard; one which permits on necessity grounds some non-disclosure of otherwise disclosable material. Justifications which have been accepted as falling within this include national security, the protection of vulnerable witnesses and the keeping secret of police methods of investigation. Clearly this principle is analogous to our
 domestic doctrine of public interest immunity. So far as European Court of Human Rights is concerned, in *Fitt v United Kingdom* the court held that the ex parte system did not contravene the defendant's right to a fair trial", and I think that is a reference to whereby the prosecution go on its own to a judge to get permission not to disclose material.

In my submission here, sir, there is nothing along those sorts of lines which would justify the Council in refusing to disclose the sort of material that has been sought from it on behalf of the Defence in the context of this abuse application. No reason has been given except that, as I understand it, it is a wrong procedural route that I am embarking on, but that in my submission does not begin to give any defence for the non-disclosure of what may be relevant material.

In my submission the non-disclosure here is serious, it is substantial and on those grounds alone a separate abuse exists which would justify on the balance of probabilities this Committee ordering a stay. Again, I confine that submission in relation to the first six charges. The last two charges would fall outside the bounds of that submission.

And finally, sir, can I come to a last separate alternative submission which I flagged up on the first day of this hearing which is a submission in relation to Head of Charge 2 only. This is the case you will recall in relation to Patient A, sir, in which the parents of the child patient concerned have expressly refused consent to the disclosure of their child's notes.

The nature of the charge, as you can see, is a failure properly to monitor the patient once those prescriptions which are listed there had been made and that there was irresponsible monitoring in the way set out there.

The nature of the defence to the charge as currently given by Dr Cosgrove, I hope my learned friend does not mind my putting in a document that he has kindly provided me with this morning. Well I am not sure I need put it in and I am not sure whether he intends to put it in, but it is a response to the Rule 6 letter, dated 13 November 2002, and it deals with the original Head of Charge that was communicated to the Doctor in the Rule 6 letter. I do not think it has been substantively altered between that and its appearance in the Notice of Inquiry before this Committee.

It states that:

"It is admitted that by May 1999 Dr Cosgrove prescribed Risperidone and clonidine to the Patient DB to be taken with 130 mgs of Ritalin daily",

and it goes on to say:

"Dr Cosgrove strenuously rejects any suggestion that his prescribing for the patient was irresponsible or inappropriate. Dr Cosgrove was in regular communication
with Dr Holmes, Consultant Community Paediatrician at Salisbury, who was doing the monitoring of DB on behalf of Dr Cosgrove who was consulting in Bristol. The GP knew that Dr Holmes was monitoring DB”.

I think it would be fair to say that that version of events is challenged by Dr Holmes in the Witness Statement he has made in relation to this matter.

My submission is that the Doctor is fatally hamstrung in not being able to refer and have access to the patient's notes in order to assist him in mounting that defence, because it would obviously be appropriate and helpful in asserting that he had properly monitored this patient to have access to, not only Dr Holmes' notes, but be allowed to deploy his own private notes and indeed to have access to the patient's General Practitioner Notes. That is a flaw which, if it is not subject to remedy, in my submission makes it unfair and again an abuse that the Committee should proceed to hear that particular case.

I am sorry that I have been so long in developing those submissions, sir, but those are the submissions I make on behalf of Dr Cosgrove.

THE LEGAL ASSESSOR: Mr Morris, could I ask you a couple of questions that have arisen? In the course of your submission on legitimate expectation you referred to the delays that had occurred.

MR MORRIS: Yes.

THE LEGAL ASSESSOR: Do you want to say anything to the Committee on Dr Cosgrove’s right under article 6 to have a trial in a reasonable period of time?

MR MORRIS: I am not advancing a submission that there is abuse arising out of delay. There has been delay here, but the criteria for establishing abuse purely as a result of delay are ones I do not seek to meet on behalf of Dr Cosgrove.

One of the matters that needs to be established in order to cite delay as a reason for staying a hearing is that the doctor has thereby been prejudiced, and this is whether it comes under article 6 or the common law by virtue of the delay. Clearly, there is an element of prejudice here for two reasons, firstly, the lapse of time and the failure of memory that that inevitably causes, but, secondly, and perhaps more importantly in the context of this case, is that there was delay between the time when he was either told that he was not going to be subject to disciplinary procedures in relation to three of the cases or between the arising of the legitimate expectation he was not going to be dealt with by way of disciplinary or any other proceedings, inasmuch as, once those promises had been made or that expectation had arisen, he was entitled, and did to some extent, to sit back and not to commence the preparation of any defence to any disciplinary charge.

THE LEGAL ASSESSOR: The other point is the burden of proof. The burden is on you. The standard of proof is the balance of probabilities?

MR MORRIS: Yes.
THE LEGAL ASSESSOR: Can I make sure I have understood your argument on a particular point correctly? As a free standing challenge you are saying, in relation to the counts where there has been an express communication saying that the count will be dealt with under the performance procedures, that it is an abuse of process to go back on that express communication.

MR MORRIS: Yes.

THE LEGAL ASSESSOR: Have I understood you correctly that that stands separately from the general abuse argument that you have mounted, that the breach of the letters which say that charges are going to be dealt with under the performance procedures go to show that the whole prosecution is an abuse?

MR MORRIS: Yes. That is separate from those matters contributing to what I would call the index or indices of suspicion in relation to the effect of head of charge 6.

THE LEGAL ASSESSOR: I am just checking here, rather than making any assertion. This is the second category of breach of promise where there has been an express communication. As I understand it, it is charge 9, charge 7 and charge 3.

MR MORRIS: In 3, 7 and 9 there were express promises that they would go to performance.

THE CHAIRMAN: These were the category 2 charges.

MR MORRIS: That is right, but equally in relation to my breach of promise argument is the other category where a legitimate expectation arose, in my submission. Those are heads of charge 2, 6 and 4.

THE LEGAL ASSESSOR: Do you have any authority which relates directly to the GMC procedures? I understand you have authorities which relate to the criminal jurisdiction. Do you have any authorities which relate to the specific jurisdiction?

MR MORRIS: No, I do not.

THE LEGAL ASSESSOR: Can I say that I cannot think of its name, but I am aware of an authority which says that the GMC, or I have read an authority whose name I cannot now recall, but it was reported in the last eighteen months to two years, which says that the GMC is under a duty corresponding to the duties placed on the prosecution in a criminal trial?

MR MORRIS: I am not aware of it.

THE LEGAL ASSESSOR: I cannot remember its name, but it was reported in the Times Law Reports, certainly within the last two years. I remember noting it, that there is an express statement that the GMC, as the prosecuting body, is under a similar duty to that which the Crown Prosecution Service would be under vis a vis disclosure.
THE CHAIRMAN: In the absence of that authority, would it not be incorrect to take this into account at the present time?

THE LEGAL ASSESSOR: This is what I am canvassing with learned Counsel.

MR MORRIS: I will certainly see if I can dig anything up over the adjournment on that. I have always rather assumed that that is the approach that has been taken by all Conduct Committees and it really arises out of rule 50, dealing with the receipt of evidence, which makes specific reference to the receipt of evidence admissible in criminal proceedings, allied with the fact that the nature and procedure of Conduct Committees is clearly disciplinary. The burden is on the Council. The standard of proof is the criminal standard of proof. For that reason, the approach in criminal courts is analogous and useful and authoritative in guiding the Conduct Committee.

THE LEGAL ASSESSOR: Perhaps I can summarise it by saying I believe there is an authority which expressly says that.

THE CHAIRMAN: Thank you very much. It is now nearly one o’clock.

MR PEARCE: Sir, I was going to rise to say that my learned friend’s very detailed submissions referring to a large number of documents, some of which we have seen before, some of which I have and you have and some of which I have not seen before, clearly will require some detailed response by me. I had anticipated many of the lines he was going down. I have to say I had not anticipated all of them. If come, let us say, two o’clock I am close to but not ready to start, which I fear may be the position, I wonder whether you would grant me an indulgence. I am not suggesting this will take a very long period of time, but I do feel an hour might be a little tight.

THE CHAIRMAN: I can see no objection to that. We will agree to it. The panel will rise. We will reconvene at two o’clock or shortly thereafter.

(The Committee adjourned for lunch)

THE CHAIRMAN: I assume you have nothing further to say just now.

MR MORRIS: I have not, sir.

THE CHAIRMAN: Mr Pearce.

MR PEARCE: Sir, my submissions this afternoon are intended to persuade you that the application to stay these proceedings on the grounds of abuse of process, whether in whole or in part, is misconceived, that the facts and matters drawn to your attention by my learned friend provide no proper basis for staying these proceedings on the grounds of abuse, again whether in whole or in part, and, in addition, to seek to persuade you that, insofar as it is relevant to your determinations, the GMC has behaved properly throughout this case in its obligation to disclose relevant documentation.

In so submitting to you I seek to deal with matters in the same order as my learned friend, I anticipate, although I am often proved wrong, rather more briefly than my learned
friend. That is not to criticise his length, but to indicate to you that I will not, in the
course of my submissions, need to deal with matters, in particular in respect of the
Church of Scientology, but also to some extent in respect of the history of the various
complaints and charges in the notice of inquiry, at quite the same length as my learned
friend has done.

May I then turn specifically to what I understand to be the first of my learned friend’s
submission? That is the submission that charge 6 is a fraud, for want of a better way of
putting it, and that, it being a fraud, that taints the entirety of the rest of the charges before
you. As I have submitted before, and I think as is clear, the suggestion that this is a fraud
really amounts to one of two alternative positions on behalf of Dr Cosgrove. The first is
that Mrs D is indeed the mother of a child, D, and presumably the mother of a child who
was treated by Dr Cosgrove, but that she does not genuinely instigate the complaint that
appears in charge 6, or, in the alternative, that if she does genuinely instigate that
complaint, she is not genuinely the mother of child D.

The logic of this seems to us to be one of two things: either that the person who gave
evidence last Wednesday, being the true mother of child D, but not being the genuine
complainant, lied in adopting the complaint that is put in that letter of complaint. In other
words, although she was not genuine when she started the complaint, she does now
complain against Dr Cosgrove. She is part of some conspiracy, therefore, against Dr
Cosgrove, whatever the reasons for the complaint being instigated in the first place. That,
put simply, we submit is madness.

Alternatively, she is lying when she says that she is the genuine mother of D and in
describing his health. Sir, you heard me re-examine Mrs D on issues relating to her son’s
medical history. I seek to put before you as an exhibit on behalf of the Council a bundle
of medical records. This is the bundle. (Same handed) I have not photocopied them,
either in whole or in part, because there is a large number of documents. I seek to invite
you to look at ten specific documents that I have flagged up with Post-it notes, but at the
same time invite you to bear in mind the entirety of any documentation that you may see
within these medical records. It is not necessary for my submissions for me to go into
detail that infringes any issues of confidentiality here. The point can simply be made, in
my submission, that if you look at these records, look at simply those ten flagged
documents or any other documents you choose to look at, but the ten flagged documents,
I submit, make the point very straightforwardly, it is clear, firstly, that when she gave
evidence Mrs D knew a great deal about the medical history of the child who is described
here.

It is clear, secondly, that the child to whom these medical notes relate was diagnosed as
suffering from ADHD. It is clear, thirdly, that this child was treated by Dr Cosgrove. I
submit those are points that can be made simply by reading the ten flagged documents,
but would be confirmed by further reading of the file from beginning to end if you chose
so to do. I produce that bundle to the Committee. As I say, I apologise for it being in
original form but it seemed more sensible than any other route. I think that is C5.

THE CHAIRMAN: It would be C5. I think we could look at that when we go into
camera.
MR PEARCE: Precisely so, sir. I think that would be sensible.

MR MORRIS: For my assistance, I do not suppose the original bundle is paginated.

MR PEARCE: It is not. Would it assist if I had those ten marked documents photocopied? I did not do it in advance because I did not want it to seem as though we are selectively taking documents out of a body of medical records. We say they are only illustrative. If my learned friend wishes those ten documents, certainly…

MR MORRIS: The problem is I have not had a chance to look at these ten documents. I do not know which have been flagged up.

THE CHAIRMAN: It would be only proper that Mr Morris should see that. The two options are that we allow you a few minutes just now or we get them photocopied.

MR MORRIS: I certainly do not want to interrupt my learned friend. I suggest we proceed and they could be photocopied and I can look at them in due course.

THE CHAIRMAN: They should be photocopied. I do not think that should hold us up.

MR PEARCE: No, I think not, sir.

In my submission it will be abundantly apparent to you, if it was not from her evidence last Wednesday, that the person who gave evidence is, indeed, truly the mother of a child who had ADHD and who was treated by Dr Cosgrove. What is the attack upon that? Sir, I will not labour the point about the handwriting evidence. The point there is abundantly clear. Mrs Marsh quite rightly conceded, having originally suspected that there was a difference in writing between various signatures, she quite rightly conceded on seeing a larger number of documents that there were similarities – similarities not just sufficient to make her retract the original opinion that on balance she thought the documents were not signed by the same person, but, as it were, to swing the other way and to say that on balance she thought they were. You have copies of the signatures. If you wish to be – and I say so with respect – amateur handwriting experts, you may do so and look at them but you do not think that you need any more than Mrs Marsh’s evidence to be convinced that the entirety of those documents were, indeed, signed by one and the same person.

Sir, that for the moment is to make submissions relating only to evidence independently of Mrs D, but what of Mrs D herself? You heard her give evidence. You may think that she was honest and convincing in what she had to say and that at no point in seeking to cross-examine her did she behave in a manner in Mr Morris’s cross-examination that would suggest to you that she was anything other than a straightforward and honest witness who appeared before you.

My learned friend has, I think, identified four points today that may cast doubt upon her honesty or genuineness. The first is the confusion between Bath and Bristol. Well, you heard what Mrs D had to say about that. I cannot put it any more vividly than she did. She said she was not good at geography. I do not dispute my learned friend’s contention that Bath and Bristol are different cities. However, in my submission, geographically close, perhaps for someone who does not know that area at all and then a confusion as to
where she may have gone, perhaps encouraged by documents, some naming the Bristol Priority Clinic, some naming an address in Bath. Who knows? You may think her explanation for that was thoroughly convincing.

Secondly, sir the confusion between a hospital and a clinic. Well, I ask you to consider whether that is in any sense a meaningful confusion that casts any doubt upon her genuineness or honesty.

Thirdly, the variable spelling of the surname. That does undoubtedly raise a question in one’s mind. Most of us, I venture to suggest, spell our surnames consistently one way or another, but bear in mind here for a moment what Mrs Marsh had to say in her evidence. She said that signatures signed with the “p” and without the “p” are both, in her opinion, signed by the same person.

If Mrs Marsh is right, there is someone out there – and presumably it was the Mrs D who was before us but there is somebody out there – who alternately spells their signature with or without the letter “p”. If that be so – and Mrs D says to you firmly, “Yes, they are all my signature” – if that be so, then it may not for a moment matter why she spells her name differently in different circumstances. She gave you an explanation – “It depends how other people address me, it depends on the document.” Whatever the explanation was, you may think that does not in any way, shape or form undermine her honesty or genuineness before you.

You might also bear in mind that on this point as well as the handwriting evidence, the various documents from which those signatures are drawn all again clearly relate to the same person and the same mother, so again there is independent evidence from Mrs D that the same person is signing the signature but in different ways.

The fourth point is that the letter of complaint dated 18 August 2000 that you have seen is unsigned. Well, I hear what my learned friend has to say about that point. Signed or not, it is a document that Mrs D has adopted before this Committee and you may think that there is no basis whatsoever for any suggestion that that was not genuinely intended to be her witness evidence and genuinely signed on that basis.

Her evidence was detailed. It was detailed in terms of the circumstances of the consultation, it was detailed in terms of her son’s condition, it was unshaken by cross-examination.

Document C1 – that is the document, if you recall, that was signed by Dr Cosgrove and Dr Bramble relating to Risperidone. That was a document that Mrs D said had come into her possession. How does it come into her possession unless she is genuinely a mother of a child treated by Dr Cosgrove?

Frankly, sir, if Mrs D is not genuinely who she says she is, why does she come to this Committee to lie? Why does she put herself in this situation? I suspect at this stage one moves on to the second area of my learned friend’s submissions on this first point, which is the role of the Church of Scientology and the Citizens Commission on Human Rights and Mr Daniels. Implicit, I suspect, in the submission, is that Mrs D, if she is a fraud, is a fraud because of her allegiance to or sympathy with the Church of Scientology. You
heard her deny being a scientologist and you heard the terms in which she denied it –
baptised, taken first Holy Communion in the Roman Catholic Church, married in Chapel.

You may think again that evidence rang true and was forceful evidence, but that, I
suppose, does not of itself mean that she could not have sympathy with the Church of
Scientology or its aims.

At this point I want to address you on the documentation about the Church and the
Citizens Commission that has been produced. In this respect I start off by repeating
submissions that I made to you earlier. I neither accept nor reject the accuracy of
anything stated in the Foster report. I see the contents of other documents that clearly
come from the Church or from the Commission, that have been provided. One can see
what is said there. Whether what is contained in it is accurate or not is another matter but,
for my submission, not one that you have to consider.

It is right that you ought to consider, sir, that the Church of Scientology, at least in
respect of some of its practices, has what you may think are perfectly respectable
defenders as well as critics. You heard from Mrs D herself in that regard saying in that
in one area – that is to say psychiatric treatment – she shared views with the Church. One
of your members had some sympathetic views towards one aspect of an organisation
associated with the church. That may simply suggest, sir, that there is a range of opinion.

How can you begin to judge that?

How can you begin to say – and this is at the core, as I see it, of my learned friend’s
submissions – how can you begin to say that this prosecution must be tainted because the
kind of thing that the Church of Scientology would do would be to put up a false
complainant, to encourage false complaints, to orchestrate campaigns against
psychiatrists? Even if they do orchestrate complaints against psychiatrists, where is the
evidence of any orchestration by them in this case?

Indeed, one of the points that may have struck you very forcefully from all of the
documentation that has been disclosed to you, is that the Citizens Commission on Human
Rights is only alleged to have been involved in one of a series of complaints. If this was
truly an orchestrated campaign, then how come, you may think, there is no evidence of
any involvement by the Church, by the commission, by Mr Daniels, on any of those other
complaints? That, in my submission, goes strongly to suggest that there is no
orchestration by the Church of Scientology.

Sir, on Monday of last week it was being suggested that the lack of progress in the
complaints against Dr Cosgrove until mid to late 2002, followed by a sudden flurry of
activity, was quite possibly if not probably the consequence of communication from the
Church of Scientology that had the effect of stirring the GMC into action. You are aware
– and my learned friend has made reference to it on at least two occasions now – that he
has seen a bundle of correspondence and some of it is now before you because it has
other relevance in the case – and a bundle of documentation that leads him to make the
concession, as I understand it, that there is no evidence of a letter from the Church of
Scientology that in fact stirred our side of the process into action in 2002.

I will if I may, sir, refer to another of the documents that came into existence at or around
that time. It is not one that is currently before you. It is a memorandum of 5 September

TranscribeUK
020 8614 5799
2002.

THE CHAIRMAN: This will now be C6.

MR PEARCE: I am obliged, sir. Sir, if I may read this for the purpose of the record. It is a memorandum from a Mr Peter Lynn to Dr Malcolm Lewis. Paragraph 1:

“I should say at the outset that the office needs to apologise for the delays that have occurred in the handling of this series of cases. You last screened cases relating to Dr Cosgrove in February of this year (please see your note flagged C) and the oldest case in these files dates from 1997. I have placed the latest memos about all the cases on top of the first file. I have picked this up following Ann O’Sullivan going on sick leave and, unfortunately, Ann is the person who knows about the history.

1a One of the difficulties here has been that information has continued to come in about Dr Cosgrove and additionally the case has been passed around a number of caseworkers, went to performance and then came back to screening. In any event, these cases form part of the backlog that we are committed to clearing by the end of this month. Following my arrival in screening, this was a doctor I discussed prioritising with Ann but as you will see from my memo of 16 August 2002, below, Ann went on sick leave that week and will not be back until October. I have therefore taken over the case and moved it on by consulting our in-house solicitor, Peter Steel. The short summary of his advice is in the e-mail immediately below this memo but Peter has, very helpfully, reviewed the files and drafted rule 6 allegations. They are at the end of this tag.”

You will recall that that e-mail is a document we have seen already, I should say, sir.

“The allegations were drafted on the basis of the following ten files”

and then numbers are there listed. Turning on to the next page:

“We additionally have yet another case, 2002/1616. Peter Steel did not receive this file and it was recently passed to me by Seaton Giles, in light of the previous cases. I agreed with Seaton that we would link this with the other files. I have drafted an allegation in relation to the referral from Dr M about seeing JR without a proper referral from a GP – which Dr M specifically raises as an issue. I would be grateful for your views on this complaint and whether you feel this in itself raises an issue of SPM. There is no specific provision in GMP. I would be grateful for your comments also on the practice of making out specimen prescriptions to be then prescribed on the NHS. Can this be regarded as acceptable practice? It sounds very questionable to me and I have drafted an allegation for consideration. In relation to JE, I think there is insufficient information as we have no medical records, specific dates and, importantly, the events occurred six years ago. I therefore do not suggest
considering PPC on those matters, although if you want to pursue them separately we could do so. I should say that at that stage the PPC could initiate further investigation if they thought it appropriate.

4. Again, I am sorry to be presenting these cases in this way at this stage. However, Peter Steel has done a lot of work to focus on the allegations and I think we are ready to move to the PPC on the cases you previously screened and for you to consider everything else.

5. After initially reviewing these files, please give me a call if you wish to discuss before reaching a decision.

6. I hope you will excuse my audacity in requesting that you look at these files and return them to us as soon as you can, given that we are committed to getting a screening decision regarding PPC before the end of September.

7. Again, if you wish to discuss any aspect of these cases at any stage, please ring me.”

Signed, you may think, “Peter Lynn” and below that you may think there is a handwritten note that starts off “Medical Screener” and I think is rather difficult to read but you may think is signed “Malcolm Lewis”. I leave that to you to consider.

What is clear from that memo - which I have read in full because it does give us information that has not previously been available – is explanations being proffered for delay in this case and apologies in that regard, as well as explaining the on-going process at that stage.

Amongst other things that memo, in my submission, clearly gives the lie to any suggesting that it was activity by the Church of Scientology or the Citizens Commission or Mr Daniels that led to a sudden flurry of activity in later 2002.

Sir, those submissions deal in principle with the respects in which the veracity or genuineness of Charge 6 is attacked, but my learned friend then seeks to raise the indices of suspicion, as he puts it, by raising certain other specific points and it is to those I turn now.

The first is that it is said that there was a delay of 21 months in the GMC responding to an enquiry from the MPS about Mrs D and her signature. The relevant documents you have already been referred to are D18 and D19 and I accept the time scale as put there. However, what that submission does not take account of is some other correspondence on this issue and that I will refer to you because it is some time, I think, since you have looked at it. It is in D4.

D4 comprises three documents that were produced for handwriting purposes but as it happens the second one relates to this issue. The second document there is a letter dated 21 June 2001 from Mrs D, addressed to a person at the Fitness to Practise Directorate of the GMC.
“Mr Brian Daniels of the Citizens Commission on Human rights has contacted me after speaking with you on Tuesday morning. He has informed me that the procurement of my son’s medical records have been delayed due to a possible confusion over names. In reviewing my previous letters to the GMC, I have spelt my surname”

and she gives one spelling with a “p” and then she says

“as opposed to”

and she gives another spelling without a “p”.

“This may have caused some confusion for Dr Cosgrove so I felt I should write to provide you with evidence to confirm the correct spelling. I have enclosed a copy of my driving licence as proof of my surname. I hope that this will resolve any misunderstandings.”

Now that letter dated 21 June 2001 falls what – some four, five months after the letter from the Medical Protection Society at D18 raising this issue and significantly more than a year before the response of the GMC. So, any delay that there may have been – and I am not seeking to defend a 21 month delay in replying to a letter – whatever the explanation is, it is not that this is a matter that went to sleep. On the contrary, the GMC raised an enquiry about the very point that is being raised on the part of Dr Cosgrove.

In what sense does that delay in responding to the letter suggest that in some way there should be a higher suspicion about the genuineness of Charge 6? In my submission, not at all. On the contrary, the point was raised with Mrs D and she responded to it.

You might note the reference to Mr Daniels in that letter. Conspiracy theorists might say that this is yet another example of Mr Daniels or the Commission orchestrating complaints. Others might say that Mr Daniels clearly had an interest in these proceedings and a concern about the complaint in relation to Dr Cosgrove and that he was sufficiently concerned to be involved in it, to be assisting Mrs D, to be communicating with her as well as the GMC. What it does not suggest in any way, shape or form is any orchestration on his behalf.

The second area in which we are said or you are invited to have a higher degree of suspicion relates to an article in the Bath Chronicle on 20 September 2002 and a Press Release leading to it, those being D20 and I have not written on it but I think it must be D21, I take it, the article. Yes, D21 is the article respectively. And the point is made perfectly accurately that the article, and therefore presumably the Press Release precede the Rule 6 letter.

That is perfectly consistent with Mr Daniels, or the Citizens Commission on Human Rights, enquiring about the state of matters relating to Dr Cosgrove and putting out a Press Release that they understand that that represents the position. It does not, in my submission, in any way suggest that there is orchestration going on, that the Commission is attempting to apply undue, unfair or wrong impression on the GMC. I do not dispute
that the Commission has a position - has a stance - on this. I do dispute that there is any evidence to suggest that its stance or position has unduly influenced the GMC in the prosecution of this case.

The third area in which it is said we should have a higher level of suspicion is the breach of promise or the denial of a reasonable expectation in respect of how certain charges were to be dealt with.

Now, sir, a little like my learned friend in his submissions, I will deal with this point now. In many ways what I have to say simply needs to be repeated in due course when we get to the freestanding abuse arguments relating to this, but I deal with it now because it fits in neatly to this stage of the submissions.

Sir, the remarkable point - and, in my submission, it is remarkable - about this area of my learned friend's submissions is that it was raised for the first time today. It was not even, in my submission, raised last Friday. If you have any doubt about that then I invite you to look at the transcript for last Friday, and in particular Page 3 and the paragraph at letter capital E, for the indication that this was not how the case was being put then.

I would read the relevant paragraph if I had not misplaced that day's transcript. Yes, Page 3, paragraph E:

"There is a suggestion in the various memoranda that went to and fro within the GMC about this decision ..." (That is the decision to go down the Conduct route) "... that that decision could be justified on the basis that further information had come to light about Dr Cosgrove. However, on the face of the documentation that I have all the complaints date from 1999, 2000 or earlier and it does not appear to me that there was any further fresh information that would justify the Council in deciding to take a wholly different approach to the treatment of this information and complaints.

If that is right, it would, in my submission, amount to an unfair use of the investigate ..." (and I think it may be investigative) "... powers of the General Medical Council and would amount to an abuse, which I would seek to lay before you".

Now, if my learned friend's submissions are correct, then what has happened here is that Dr Cosgrove has been led to a belief either in respect of some charges that no action would be taken at all, or in respect of other charges that the action that would be taken was in respect of Performance. And that therefore when he received a Rule 6 letter raising various allegations of misconduct he would, you may think, if he had been in any way whatsoever misled, deceived, led up the garden path -- he would, you may think, have been frankly up in arms. You may think that if there was any legitimate complaint about the change between professional disciplinary proceedings along the Performance route to those along the Conduct route, you may think that he would then and there have
been shouting from the rooftops in complaint about what was going on. But, no, no such complaint was raised. No such complaint was raised then, at the beginning of these proceedings last Monday or, indeed, in my submission on Friday of last week.

The point is quite simply this. Matters come to light in the course of documents that, in my submission, appear to give the Doctor a technical argument against us that we cannot explain a change in decision-making and that it is sought to use those matters in order to persuade you to stay these proceedings as an abuse of process. But the very fact that never before until this stage were these points raised is the best indication you might want that there has never been any misleading of Dr Cosgrove. There has never been a suggestion in which he has felt unfairly treated in the fact that proceedings were originally, it is being suggested, not going to be proceeded with and then there was a change of mind, or were going to be proceeded with down the Performance route and then it became the Conduct route. Dr Cosgrove has never felt at a disadvantage, prejudiced or unfairly treated because of that. If he had, the point would have been raised in my submission. This is a last minute point that arises out of seeing certain documentation.

And even then, sir, the documentation does not give Dr Cosgrove the argument. The argument arises out of the fact that he was originally told, "Either nothing or Performance" and then in 2002 he was told "Conduct". Nothing in any of that documentation that you have now got makes him any the more misled as to what the true position was. Nothing in that documentation that you have now seen gives rise to some greater expectation than he can possibly have had in the past. What matters is what was his expectation, let us say, on the evening before he receives his Rule 6 letter? Did he then feel he had had the promise or the expectation? How had he been treated? Yet, this complaint is not raised.

Now in that memorandum of 5 September 2002, C6, you will have noted, sir, when I read through it, that at the top of the second page there is a reference to a case 2002/1616; a case passed on by Seaton Giles. It is clear to say from that, sir, that at the time of that letter there was indeed new information available in Allegation 2002.

Look at D22, the substantial bundle of documents relating to the process at this time, and in particular that table of open cases - the open cases list it is called that appears there. On the second page of the table, the last complaint: "2002/1505 01 Home Office 02 West Yorks Police". So, again there is new information available at that stage.

And, indeed, you will have noted that throughout the memoranda that are to-ing and fro-ing at this stage there is reference to information coming in and it being considered. So, it is not right to suggest on the face of this documentation that there was no new information in 2002, or at least later on in 2002.

But let us actually turn to the merits of this abuse point. I have said already that if this was a good point it would have been raised a long time ago, but what actually is being said? Well, in the legitimate expectation cases it is being said that such time had passed that Dr Cosgrove could and presumably did legitimately think that those cases were not going to be pursued.
I have raised already the suggestion that if he genuinely thought that he might have said it a long time before today, but more to the point what is it in the passage of time at this stage that would have led him to that conclusion? It is quite apparent that there was a period with relative inactivity, and I do not defend that as I have said already, but equally from time to time there were periods with flurries of activity with letters being sent including, you will have seen, contact with Dr Cosgrove.

So, where does this suggestion of legitimate expectation arise? Where does it come from? Simply that passage of time? In my submission there is nothing in that to give rise to such an expectation, nor as far as I am aware nothing in any of the authorities to suggest that the mere passage of time - even very lengthy passage of time - will be held to give rise to such expectation.

That is the legitimate expectation point, sir, and then the other group - the promise group. Now if I follow my learned friend's submissions correctly on this group of cases, what he is saying is not so much that the Doctor was promised the case would go down the Performance route, but that implicit in that promise is that it would not go down the Conduct route because that is the real complaint, is it not? That it has gone down the Conduct route when presumably it is being said it should not have done so and that, therefore, presumably that promise is implicit in the promise that it goes down the Performance route.

Well, where is the promise? There is no such promise. There is a referral to Performance Procedures. There is nothing, in my submission, in the Act or the Rules that prevents a case being sent down Performance Procedures and then a further decision being taken to refer that case to a Conduct case.

It may well be that it would be oppressive on an individual doctor to do that. It may be that it would be very rare for a case to start going down one route and to change to another route. I am instructed that it does happen in some cases, but more to the point and more significantly for your considerations there is in my submission nothing in the Rules to prevent that happening. There is nothing in the correspondence with Dr Cosgrove to indicate that he was given any guarantee, promise, or call it what you will that this case would not be dealt with by Conduct Procedures.

Sir, I will return to the significance of the alleged legitimate expectations or promises when I deal with those as freestanding allegations of an abuse of process, but the question for the moment - because we are still dealing with Charge 6 and the level of suspicion on Charge 6 - is where does this take us? Where does this change of decision as to how the professional disciplinary matters are to be taken to, how does that lead to a greater degree of suspicion about the motivation of the prosecution?

You have laid bare before you a series of memoranda and screening decisions and such like. Where is the suggestion from any of those documents that there has been some impropriety, some manipulation, some bad faith?

And it is significant to note the way my learned friend puts his case on this point because, when he has spoken of bad faith and manipulation and such like, he has been clear in his submissions in saying that he is not making that allegation against the GMC. He makes
that allegation against the Citizens Commission, possibly the Church, possibly Mrs D, but
he does not make that allegation against the GMC other than to suggest that the GMC is
the unwitting victim of manipulation by others.

Well, where does this change from Performance to Conduct fit into that suggestion? How
does that make in any sense the GMC an unwitting victim? An unwitting victim of what?
There is no evidence whatsoever to suggest any undue pressure that has led to that
change.

Sir, you must bear in mind throughout these submissions a point raised quite rightly, if I
may say so, by your learned Legal Assessor last Monday that the burden of proof lies
upon the Doctor and, of course, he only has to satisfy you on the balance of probabilities.
However, where there is simply no evidence on the point - and there is, in my
submission, no evidence to suggest any manipulation of the GMC, any bad faith or bad
behaviour on the part of the GMC - then he cannot in my submission come close to
satisfying the burden, even on the balance of probabilities, that there has been some
misconduct that has affected the prosecution process in this case.

Sir, the next area in which my learned friend asks you to have a higher level of suspicion
is in relation to the non-disclosure of documentation. Well I suppose if the
non-disclosure of documentation were to be considered to be relevant to your level of
suspicion about bad faith, it would have to be implicit in that that whoever has made the
decision not to disclose any further documentation is themselves acting in bad faith, or is
being manipulated by the parties whom I keep mentioning and is a victim - an innocent
perhaps victim - of some other person’s manipulation. Well in my submission there is
simply no evidence of that, sir, any more than there is of bad faith or bad conduct in
respect of the decisions as to prosecution.

My learned friend seeks, as I understand it -- and I am sure I will be corrected if I am
wrong. He seeks documentation essentially relating to the original screening decisions in
certain cases. He says that this documentation is highly relevant. Well, I ask to what is it
highly relevant? It is not that original screening decision that is being attacked here. It
was the later screening decision of Dr Lewis.

It is said that disclosure of these documentations might assist, as I understand it, in the
submissions relating to abuse. Is it said they will assist in any way in the substantive
issues in the case? In my submission, they could not possibly do so. But even in respect
of the abuse proceedings, sir, when one focuses one’s mind on what actually is being
alleged here then screening matters back in 2000/early 2001 are going to have no bearing
whatever.

Sir, those who instruct me and my lay client take their obligations of disclosure seriously,
and I invite you to say that their willingness to co-operate and be reasonable is amply
demonstrated by events last week when first of all we disclosed a quantity of
documentation sought by my learned friend in order to deal with issues of delay, secondly
we willingly produced Mrs D to give evidence before you on the issue of abuse and,
thirdly, when these issues were raised on Friday we did not simply say, "We will not
disclose the documents to you". We considered our position with very great care.
But, sir, in my submission there must properly be drawn a line somewhere. There is no basis, in my submission, for suggesting that any of this documentation will in any way either undermine our case or assist the Doctor's case. These are historic matters. You are going to be concerned with the substantive issues of what the doctor's conduct was and matters relating to that. How someone came to a particular judgment in the past will be irrelevant to that. Moreover, when you are being asked to judge the issues of abuse that my learned friend raises, then the basis of that decision making back in 2000 or early 2001 will help you none the more.

You must bear in mind, in my submission, that the consequence of a finding of abuse of process and a stay of proceedings is that those who have a legitimate interest in the case, those who complain and raise allegations and have a legitimate interest in the proceedings, are denied their opportunity to appear in front of you and to state what they have to state and make any allegations they have to make.

Abuse of process arguments, sir, must be considered with very great care, because precisely what they do is to stop you hearing the case on its merits. They say you should not even get to that stage and it is with very great care that you should look at any argument that suggests that you should not in fact hear a case on its merits. Of course there are circumstances where proceedings properly can be stayed, but this comes nowhere near that level, in my submission.

Finally, dealing with the issue of disclosure at this stage, when my learned friend in his submissions was putting forward his argument as to the relevance of documentation, he indicated that the documents he was seeking – and my note of his words, I hope, approximately accurately is – “The disclosure of documents may give an avenue for the doctor to explore which he currently does not know.” Sir, that, in my submission, is fishing for documentation. That is precisely what parties to litigation may not do. Of course we have an obligation to disclose that which is relevant. As I have said already, we treat that obligation seriously. This is, I regret to say, the mere fishing for documentation in the hope that something might be there. When you think about what that hope might be, is the reality here that what is being sought is some suggestion that the Church of Scientology or the Citizens Commission or Mr Daniels is somewhere mentioned on some other case and that this proves the conspiracy? Is that what they are fishing for?

In my submission, these abuse of process arguments would, if allowed to continue and continue and continue, on the basis that sooner or later they would seek to find some such evidence, there is no basis to suggest that some such evidence exists.

Sir, may I at this point turn to the question of the significance of what has been argued in respect of charge 6? Insofar as it is suggested that Mrs D is a fraud, then that, you may think, would give Dr Cosgrove a cast iron defence to those allegations. He could not possibly be convicted of those allegations in charge 6 because the evidence on which they were based would simply be dishonest and not such as could possibly persuade you to find in my favour on those issues. That is what the trial process, the process of you hearing witnesses on substantive issues is meant to determine. Dr Cosgrove does not need the protection of an abuse of process argument to prevent that happening. That will be dealt with on the evidence at the appropriate time. No. Of course, it is put much more
broadly on the basis of abuse of process, the tainting, I think it is correct to say, of the proceedings more generally.

May I refer you, through your learned Legal Assessor, to Archbold paragraph 4-54 and following? This is a section of Archbold that you have had read out to you at some length already. There are a large number of cases here cited on abuse of process. It is fair to say that in most cases abuse of process arguments have failed. In all of those cases cited there not a single case of abuse of process has succeeded unless there was evidence that the defendant’s ability to defend himself was adversely affected by the alleged abuse of process, or there was conduct by the prosecuting or state authorities that was manipulative or deprived the defendant of a protection at law. I think there particularly of cases where people were illegally brought into this country – Mullen is an example of that cited at 4-56 – and then subject to trial where, but for them illegally being brought here, the trial would not and could not have happened.

There were no cases in that section dealing with the alleged manipulation of authorities by third parties. That matter is touched upon at another paragraph in Archbold which is 4-63A, again a section to which my learned friend has referred you in the past. There it is said as follows,

“An abuse of process exists where the plaintiff in civil proceedings is in effective control of criminal proceedings against the same defendant to the extent that the prosecution are unable to exercise independently their prosecutorial duties.”

The case of Regina v Leominster Magistrates Court, ex parte Aston Manor Brewery is cited. Effectively it is the same barrister there appearing both to prosecute a case and in civil cases who thereby had in his possession information, the disclosure of which was disputed and where the Divisional Court strongly disapproved of the manner in which the criminal prosecution was being conducted.

Sir, there is, as I seek to emphasize again and again, no evidence here that the prosecution process is in any way shape or form tainted by manipulation. It is the most extreme cases, such as Regina v Leominster Magistrates Court where the court will stay on those grounds. May I contrast with that the very strong public interest in these proceedings going ahead, in respect of which I seek to cite another case to you which does not appear in Archbold and which is not in the criminal jurisdiction. There are three authorities I am going to refer to. I have referred to Leominster already and I have another two authorities. I have bundled them together and have copies for everyone. It might be useful to distribute that now as C7.

THE CHAIRMAN: Yes. (Same handed)

MR PEARCE: On the front page of C7 you will see the best report we have of the decision in Regina v Leominster Magistrates Court, which is there simply to demonstrate, we say, the exceptional nature of that particular case. I invite you to look at the second case here, a Court of Appeal decision, A Health Authority v X and others [2001] EWCA Civ 2014. It is also reported, from where this copy comes, in [2001] Lloyd’s Reps Med 139. If I may read the head note,
“On the conclusion of public law proceedings under the Children Act the local authority reported to its area health authority that facts had emerged which it considered relevant to the discharge of its duties. The health authority applied to the Court for permission for the local authority to disclose specified case papers, including two general practitioner records, of two named individuals to it. Munby J [2001] Lloyd’s Rep Med 349 held that the authority was entitled to disclosure of the papers, including the judgment in the proceedings, and an order requiring the Respondent to produce within seven days the medical records of the two named patients whose consent to production had been refused or not obtained. In each case Munby J had held that such disclosure should be subject to express conditions, including a requirement that the authority would not without the prior consent of the Court disclose any disclosed document to any person other than a specified disciplinary body on the ground that the doctor’s duty of confidentiality included a duty to assert the confidentiality in any answer to a claim by a third party to disclosure and to put before the Court every proper argument against disclosure. The health authority appealed.

*Held,* dismissing the appeal…”

It is paragraph 1 of the head note I am concerned with at the moment, although I will return more generally to this case in due course,

“1. There is a high public interest analogous to the public interest in the due administration of criminal justice, in the proper administration of professional disciplinary proceedings, particularly in the field of medicine…”

Reference is made to paragraph 19. If I take you to paragraph 19 in the judgment, you will see that that paragraph there appears. What is apparent from this case and from that analysis is that the high public interest in professional disciplinary proceedings taking place means that, in that case, the Court must, whilst balancing its duties in making a decision, consider very important the fact that the disciplinary proceedings ought, if appropriate, to take place. If you look at paragraph 20, the part of paragraph 20 which is marked with a heavy line,

“In those circumstances in my opinion the objection to production fell to be decided in accordance with the principle that determined the application for the release of the list A documents, namely whether the public interest in effective disciplinary procedures for the investigation and eradication of medical malpractice outweighed the confidentiality of the records. I do not regard the application for production much enhanced by the Regulation 36(6) duty. A balance still had to be struck between competing interests. The balance came down in favour of production, as it invariably does, save in exceptional cases.”

You will see this case may have relevance to another part of my learned friend’s submissions, but at this stage I seek to emphasize to you the importance of professional disciplinary proceedings taking place and not, as it were, being stymied by arguments that lack merit. There is no evidence of impropriety on the part of the prosecuting authorities. There is no evidence of inappropriate control by any body. There is no evidence of any abuse in the decision to proceed with charge 6 or, in consequence of that, with the rest of
the charges.

Sir, that deals at some length with the first part of my learned friend’s submissions, but makes a lot of the points that I need to make in respect of the remaining charges. May I deal with the second area and that is the legitimate expectation or breach of promise argument? I have put my submissions on the circumstances at length and they will be no better than they are already by me repeating them again. What I do see to refer to is certain passages in Archbold on this issue. If I could take your learned Legal Assessor to paragraph 4-62, and in particular on page 340 halfway down. It is a case called R v Horseferry Road Magistrates Court is cited. I apologise that I do not have a copy of the judgment. We will obtain it if necessary.

“In R v Horseferry Road Magistrates Court ex parte DPP a prosecution had been instigated despite an assurance of no prosecution given by the police to the defendant’s solicitor and after some delay. The Stipendiary Magistrate concluded that it would ipso facto be unfair to try the defendant in such circumstances and stayed the proceedings. The Divisional Court quashed the stay and remitted the matter for reconsideration.”

Here we get to the important part of the judgment, in my submission.

“Breach of an assurance not to prosecute cannot per se justify a stay. The situation straddled the two categories of abuse. In such a situation it is incumbent upon the Court to investigate what, if any, prejudice to the defendant would result from pursuit of the proceedings, bearing in mind the exceptional circumstances that must exist before delay can be seen to result in prejudice such as to justify a stay and the Court must consider whether there are special circumstances present.”

As in R v Croydon Justices ex parte Dean referred to by my learned friend, where special factors were the defendant’s youthfulness and the assistance he had given subsequent to the assurance and R v Bloomfield, the other case referred to by my learned friend, where a special factor was that the assurance had been given to the Court and would already have been acted upon for an adjournment to suit the convenience of the prosecution.

If I may take you down a little further on that same page to the next paragraph,

“Further, there is no rule to the effect that an early decision in the Magistrates Court not to proceed on one of several charges cannot in the absence of fresh evidence be revisited by Counsel prosecuting in the Crown Court (R v Murphy). The prosecution withdrew at the Magistrates Court a charge of indecent assault. Another such charge in respect of a different child being transferred to the Crown Court where the withdrawn charge was reinstated despite the absence of any new evidence.

Held that where the decision to reinstate was taken in a different court at a significantly different stage in the process and no objection had been taken by the defence at the time, the course taken did not bring the administration of justice into disrepute.”
That is what this is about. Does the decision to proceed in this case bring the
administration of justice in this context, professional disciplinary proceedings before the
General Medical Council, into disrepute? In my submission there is no basis for so
finding, even if Dr Cosgrove was given a promise or an assurance or was led into any
expectation.

It is the exceptional case that will be stayed and it will be stayed either where there is
evidence of prejudice to the doctor. By prejudice here, that does no simply mean that the
proceedings go ahead. Prejudice is some unfairness to him because of the decision and
the manner in which it has been taken that makes him the less able properly to defend
himself than he would have been had the decision been reached in a different way. That
is the prejudice situation or the particularly special circumstances called exceptional in *ex
parte Dean*.

No attempt to define all circumstances which are exceptional is ever going to be wholly
comprehensive, but when one looks at those cases of *Dean* and *Bloomfield* that my
learned friend refers to, those are very striking cases, in my submission, with very
particular features as highlighted in Archbold, which is far from the situation here. If this
case has similarity with any of the cases cited in Archbold it is, you may think, with
either *R v Murphy* or *ex parte DPP*, the two cases I have referred you to in paragraph 4-
62.

Sir, if I can turn to the third freestanding basis of an application to stay, that relates to the
disclosure of documentation, again I have set out my arguments at considerable length. I
do not think I can do better on them than I have already in terms of seeking to explain
them. May I pick up one point that amply demonstrates a point that I sought to make this
morning. This is the wrong procedural route for this kind of challenge. It is not
appropriate for this Committee to be expected to decide on abuse of process arguments of
this nature without us having the proper types of procedure that would arise in
proceedings in an administrative court. If it is being alleged that some impropriety in the
process somehow taints the proceedings, then it is that decision, the decision to refer to
screening, which ought to be challenged and ought to be challenged through the route of
Judicial Review where there would be a number of protections and very well established
principles as to the proper way to deal with the challenge.

What we have here, as I have indicated already, is fishing on the part of the doctor
desperately trying to find documents that may in some help him, and then a complaint of
a general nature that we do not disclose everything because it might help him.

Yet no basis in my submission for how it is said that these documents might assist his
case or undermine our case is put forward. We are then subject to criticism if we do not
simply disclose everything that is asked for.

I have indicated already that we seek to deal with our obligations of disclosure properly
and, if I may say so, in accordance with those duties of a prosecuting authority. Your
learned Legal Assessor did refer to a case this morning. I have not had an opportunity to
investigate that point further, not least because I have been dealing with other matters, as
you might anticipate, but I am quite willing to accept at least for these purposes that we
should be so dealing with issues of disclosure. I do not seek to make an argument out of
that but we ought properly to disclose documents if they undermine our case or assist the
defendant’s case. In my submission there is simply no basis for saying that there are any undisclosed documents that are relevant to that point.

So, may I then finally, subject to any issues that arise out of any of those, turn to the one specific area of abuse raised by my learned friend in respect of the second of the charges before you, that is to say the non-disclosure of documentation.

I have referred you already to the case of *A Health Authority v X* and the strong public interest in the proper administration of professional disciplinary proceedings. This Committee is empowered by Regulation 50 to receive evidence over a very broad remit. There is nothing in the regulations that restricts the receiving of evidence on the grounds of confidentiality. Of course the Committee would bear in mind any lack of consent for disclosure of medical records but, if documents are available, there is nothing, in my submission, to prevent the Committee receiving them and, having regard to the Judgment of the Court of Appeal in *A Health Authority v X*, everything to suggest that, when you consider the balancing exercise of whether documents ought to be received, you would lean very much in favour of receiving documents before you that might assist the doctor, even if the patient to whom the document referred did not give consent.

In my submission, insofar as documents are available, there is nothing to prevent you receiving them. My understanding is that Dr Cosgrove has a quantity of documents himself relating to this patient, there being his private notes. His concern is that he should not use those documents without the written consent of the patient. It is not clear to me what attempts are being made on behalf of Dr Cosgrove to obtain the consent, but I accept my learned friend’s statement that those attempts have been made but in my submission there is nothing in any event to stop you receiving those documents in evidence.

Insofar as other documents are concerned, my understanding is that records relating to Dr Holmes’ practice would be with the relevant Trust. We had sought – and of course timetables have changes somewhat – to have Dr Holmes bring those documents to the Committee so that they would have been available, but we discovered last week that he has since left that Trust.

Sir, there is going to be the opportunity in this case because of time considerations that have already been canvassed, to have somebody from the Trust produce those documents and, in my submission, in that case, just as much as in Dr Cosgrove’s notes, you will be able to receive and properly receive those documents if they are relevant to the issues.

In fact, sir, you will have noted that passage that my learned friend read from the letter in response to the Rule 6 letter and it appears from that passage, if I may say so, that the issue that arises in this case is as to whether Dr Holmes was asked to do monitoring by Dr Cosgrove and, if so, whether he did that monitoring. There are clearly factual issues between the parties, as my learned friend correctly identifies.

You may think that in reality that is not an issue that medical records are going to assist on in any event. It is a very straight conflict of fact between Dr Holmes on the one hand and Dr Cosgrove on the other hand as to what the arrangement between them was for
monitoring. So, in my submission, any medical records will be of limited assistance in any event.

Sir, finally on this point I refer you to the third case in that bundle of cases before you, a case called *R v Feltham Magistrates’ Court*. Sir, this is a case that deals with video evidence that was not available at trial and with the arguments that arose as to the unfairness to the Defendant in that case as to the non-availability of the evidence.

I will read the headnote, if I may:

“Where courts are dealing with an application to stay proceedings against a defendant for abuse of process on the grounds that videotape evidence has been obliterated, the court should structure its inquiries by considering whether in the circumstances of the particular case, the nature and extent of the investigating authorities’ and the prosecutor’s duty if any, to obtain and/or retain the videotape evidence in question. In doing so the court should have recourse, first, to the 1997 Code of Practice published pursuant to sections 23 and 25 of the Criminal Procedure and Investigations Act 1996, relating to the nature and extent of the duty of the police and other investigating authorities to obtain and retain material which may be relevant to an investigation and, second, to the guidelines issued by the Attorney-General on November 29 2000 concerning the disclosure of information in criminal proceedings. If, in all the circumstances, there is no duty to obtain and/or retain that videotape evidence before the defence first sought its retention, then there can be no question of the subsequent trial being unfair on this ground. If, however, such evidence is not obtained and/or retained in breach of the obligations set out in the 1997 code and/or the Attorney General’s guidelines, then the court has to go on to consider whether it should take the exceptional course of staying the proceedings for an abuse of process. There will be an abuse of process if there is either an element of bad faith or, at the very least, some serious fault on the part of the police or the prosecuting authorities and it is clear that the defendant cannot be fairly tried. The court, however, has to bear in mind the fact that a fair trial involves fairness to both the defendant and the prosecution and that the trial process itself is equipped to deal with the bulk of complaints on which applications for a stay are founded.”

I pause there, sir. It is factually a different situation but there are very few cases on abuse of process and the absence of evidence and, in my submission, what the *Feltham Magistrates’ Court* makes clear is that the non-availability of evidence will not lead to a stay of proceedings as an abuse of process without there being evidence of, in broad terms, misconduct on the part of the prosecution. That misconduct might be bad faith, it might be serious fault as well as prejudice to the defendant or, in this case, the doctor. It is argued that there is prejudice. I suggest there is no evidence of that but, more to the point, I submit that there is no evidence of any bad faith or misconduct of any nature whatsoever in respect of the non-availability of these medical records.
If you treat the lack of consent from parents as preventing the documents being disclosed, sir, then that is through no fault, we say, on the part of the prosecution.

Sir, unless I can assist further – and your Legal Assessor may have questions, I do not know – those are my submissions.

THE LEGAL ASSESSOR: Mr Pearce, thank you. I have a number of questions. Just going to your submissions on part 2 first, I just want to make sure I have understood this correctly. It is your submission that Rule 50 empowers this Committee to receive Dr Cosgrove’s notes in relation to patient A. Is that correct?

MR PEARCE: Yes, sir, that is my submission.

THE LEGAL ASSESSOR: In deciding whether to receive those notes, the Committee would take into account, would they not, the interests of patient A – I believe he is a child?

MR PEARCE: Yes.

THE LEGAL ASSESSOR: Now, as regards the records of Dr Holmes, if I have understood you correctly, the Council are making efforts to have those notes brought to the resumed hearing, if, indeed, there is to be a resumed hearing in the matter.

MR PEARCE: I have to say we have not done that yet, sir, there having been so many things going on over the last week. What I am saying is that we will do so if there is a resumed hearing. I cannot, of course, guarantee they will be here. I can only guarantee that we will make the efforts to get them here, which is slightly different.

THE LEGAL ASSESSOR: I just wanted to make sure I had understood that. There is an intention?

MR PEARCE: Yes.

THE LEGAL ASSESSOR: The other matters that I wanted to raise with you is concerning legitimate expectation.

MR PEARCE: Yes.

THE LEGAL ASSESSOR: Now, during the course of your submissions you said to the effect that the simple passage of time could not give rise to a legitimate expectation.

MR PEARCE: Yes.

THE LEGAL ASSESSOR: Can I just question that in this way. My understanding is that Article 6 of the European Convention of Human Rights as incorporated by the Human Rights Act, now requires proceedings like this effectively to be held within a reasonable space of time.

MR PEARCE: Yes.
THE LEGAL ASSESSOR: Is it not the case that if a complaint is made and just left, there will inevitably come a point in time when the person who is complained about will say, “So much time has elapsed I have a legitimate expectation that it has all been forgotten about”?

MR PEARCE: Yes, as an aspect of their right to a fair trial, yes.

THE LEGAL ASSESSOR: As an aspect of, if I can call it the English law, doctrine of legitimate expectation? I am just questioning whether or not the mere passage of time can never amount to in due course a legitimate expectation arising that there will be no further action taken on the complaint.

MR PEARCE: It can certainly give rise to an remedy if action is taken but that, if I may say so, is not precisely the same matter.

THE LEGAL ASSESSOR: I am just a little concerned about what I understood you to say, that it does not matter how long it goes on for, we never told Dr Cosgrove he is not going to prosecuted. You say that no legitimate expectation can arise in his mind that he will not be prosecuted by the mere passage of time? Is that your submission?

MR PEARCE: Yes. Nor did it arise here but I appreciate you are asking whether it could arise, not whether it did arise.

THE LEGAL ASSESSOR: Just as a matter of law, really. The other point was in relation to the promise. You said nothing in the rules or procedure can prevent a change from the performance procedure to the conduct procedure.

MR PEARCE: Nothing does, yes.

THE LEGAL ASSESSOR: I was going to ask you the question the other way round. Once the performance procedure has been instigated, if I can put it that way, and in Dr Cosgrove’s case in relation to certain charges it clearly was, I was really asking you the other side of the coin – how do you justify by relation to the rules or in law the change to conduct proceedings?

MR PEARCE: If the matter is referred to a screener, the screener has to decide whether the circumstances referred to him or her may give rise to an issue of professional conduct and is obliged to refer to the Committee if it does.

THE LEGAL ASSESSOR: Forgive me. What I understood had happened in this case was that Dr Cosgrove had been told you were going down the performance route. Is that right?

MR PEARCE: On those cases.

THE LEGAL ASSESSOR: On those charges. Later he is told, “No, it is conduct on the basis of further information.”
MR PEARCE: Yes.

THE LEGAL ASSESSOR: What I am just seeking is, can you point to a rule or some implication that can be derived from a rule as to which permits that or are the rules just silent?

MR PEARCE: The rules are silent on that point, in my submission. How it comes to be before a screener, of course, is a matter of internal practice within the GMC. This is precisely the kind of reason I say that this is an inappropriate forum but be that as it may, I appreciate the argument is launched and I have to meet it on abuse of process.

What may be being suggested – and let us be open about it – it may be being suggested that the decision was in some way perverse which is precisely what this Committee is ill placed to judge. Not that it is not empowered to do it, in my submission. It is not that there is anything in the rules that could prevent that decision being made, only that if the decision were made it might be said to be the case that is was perverse to change one’s mind.

THE LEGAL ASSESSOR: Let me just explore this because I am still not quite clear, I am a little worried about this. If Dr Cosgrove is told that his conduct on a particular occasion is to be dealt with under the performance procedure, can it not be said that he has got a legitimate expectation that it will be dealt with under that procedure?

MR PEARCE: As it happens it has been put forward as a promise but more to the point, why should that give rise to an expectation that it will be dealt with in that procedure rather than any other procedure? He knows there are going to be proceedings. That is, if I may say so, that puts my learned friend’s case another way, to suggest that it gives rise to an expectation rather than it is a promise that it will be dealt with like that. Since I might well say what is so very different about going down the conduct route than going down the performance route? There are different consequences of it. Why is one, as it were, favourable, less favourable then the other?

THE LEGAL ASSESSOR: I think this all arises out of the fact that there is no express provision for a change in the rules. Is that a fair comment?

MR PEARCE: If I may say so I am not sure that I follow that.

THE LEGAL ASSESSOR: I am not making myself clear. All I am saying is there was mention made of the rules and in this case there has clearly been a change in relation to certain counts from performance to conduct?

MR PEARCE: Yes.

THE LEGAL ASSESSOR: There does not appear to be any rules which bear directly on that.

MR PEARCE: I agree with that.

THE LEGAL ASSESSOR: Right, so it is a sort of vacuum?
MR PEARCE: Yes.

THE LEGAL ASSESSOR: That is helpful. The other point – I am sorry to jump around but I was making a list and a note of them as I went along. I obviously listened to what you had to say about the categories of conduct which may constitute an abuse of process.

MR PEARCE: Yes.

THE LEGAL ASSESSOR: At Archbold paragraph 456, there is a reference, perhaps rather confusingly called R Horsferry Road Magistrates’ Court ex parte Bennett.

MR PEARCE: Yes.

THE LEGAL ASSESSOR: I will not read the paragraph there but if I can just refer you to it. It seems to me from my reading of that authority that there is a category of conduct which may be classed as an abuse of the process which does not depend upon the defendant’s right to a fair trial being prejudiced or there being, shall I say, culpable conduct on the part of the prosecution or, if you like, someone who provides evidence to the prosecution, namely a complainant. Would you agree with that?

MR PEARCE: I agree that there is a category of abuse of process that arises out of State actions, where the State actions are independent of the prosecution process and do not affect the ability of a defendant to defend themselves.

THE LEGAL ASSESSOR: As I understood it Mr Morris relies on the case of Bennett primarily as there is this category of abuse and it does not matter whether – I am really just repeating myself. Do you accept that there is that sort of, I would not say residual category but…

MR PEARCE: Limited to state actions as is expressed in the case by the House of Lords in Bennett. The sentence – you may have noticed I picked up a file, I do have a copy of Bennett here but my recollection is that the sentence that begins with:

“Lord Griffiths said that the court had the power to interfere with the prosecution because the judiciary accepted a responsibility for the maintenance of the rule of law invoked a willingness to oversee executive action and to refuse to countenance behaviour that threatened either basic human rights or the rule of law.”

Bennett in my submission is a narrow factual situation. It is an important residual right but it is not a general line as to abuse of process. It is very specifically to the misuse of executive action. In that case that is another deportation or extradition case of somebody being brought into the country by ---

THE LEGAL ASSESSOR: I think Bennett was tricked into the country in South Africa and he was then promptly taken off the aircraft at Heathrow and he complained, summarising it probably very simplistically.
Well, just to put it this way. If - if - it was a case that there was a change from Conduct to Performance in the case of certain charges and if that is against the law (if that is against the law to put it simply) is it possible for that to fall within the category which I have just outlined? There has been a procedure -- just assuming for the sake of argument that the change from Performance to Conduct constitutes a breach of some procedural requirement for a fair trial, can that or could that ever possibly - and I am just talking about questions of law - fall within the category of abuse as we have just been discussing?

MR PEARCE: I would say it would not come close to that area of such conduct.

THE LEGAL ASSESSOR: But would it be a question of fact, or would it be a question of law then?

MR PEARCE: Well, I suppose it would be ...

THE LEGAL ASSESSOR: I am sorry to be asking you difficult questions, but this is a difficult area.

MR PEARCE: No, no. One could postulate facts where the change from Performance to Conduct involved such misconduct on the part of the executive that it did fall within Bennett, but it would be miles, or kilometres I think I am supposed to say, away from where we are here, in the sense that it would have to involve executive misdeeds, rather than some decision at this level in the GMC in my submission.

THE LEGAL ASSESSOR: Well, you will appreciate that I cannot comment on questions of fact to the Committee.

MR PEARCE: Yes.

THE LEGAL ASSESSOR: What they are entitled to expect from me is guidance on what test is to be applied and what findings are open to them on the evidence.

MR PEARCE: Yes.

THE LEGAL ASSESSOR: So, if I state the parameters it is because I want to know or I want to see ---

MR PEARCE: No, I understand that.

THE LEGAL ASSESSOR: So, you accept my understanding of the law in Bennett?

MR PEARCE: Yes.

THE LEGAL ASSESSOR: And on the premise that the change between Performance and Conduct may, looking at the law in detail, amount to conduct which might fall within that category?

MR PEARCE: I do not accept that what is being factually alleged here could ever fall
anywhere close to the Bennett category.

THE LEGAL ASSESSOR: I see.

MR PEARCE: All I am saying is that one could postulate facts involving misconduct by a Cabinet Minister involving GMC procedures which did amount to such an abuse of process, but it is an extreme area of case and what is being alleged here could not come close to it in my submission.

So, I think to try and put that accurately for what you have to direct the Committee, my submission is what is being alleged here could not amount in law to that kind of abuse of process.

THE LEGAL ASSESSOR: Right. Can I just pick you up on one thing there. I do not direct the Committee. I have to advise them.

MR PEARCE: No, you advise them.

THE LEGAL ASSESSOR: So, that apart, thank you very much indeed. I am much obliged.

MR MORRIS: Sir, I would ask for a short indulgence to enable me to look at the additional documentation that was put before you and I have not had a chance to look at from D's medical notes.

THE CHAIRMAN: Yes. Clearly there are quite complex legal issues here and the Legal Assessor is not going to give his advice this evening. He will think about it overnight and he will give his advice first thing in the morning. We could have a short break just now and come back to see if there are any issues you want to raise in relation to the clinical notes which have been made available and get that out of the way today and leave the field free to the Legal Assessor to start first thing in the morning. Would that be acceptable to you?

MR MORRIS: I would like to do that, sir, and if I may just reply as I think I am entitled to to my learned friend's submissions briefly?

THE CHAIRMAN: Yes. I also wondered if you might have had observations on the conversation that took place between the Legal Assessor and Mr Pearce?

MR MORRIS: Yes, I do.

THE CHAIRMAN: So, we will have a break just now and we will come back just before 4 o'clock.

(The Committee adjourned for a short time)

THE CHAIRMAN: Mr Pearce?

MR PEARCE: I wonder whether I might return to a point on which I was responding to
some questions raised by your learned Legal Assessor a moment ago, sir, and that is the decision of the House of Lords in *ex parte Bennett*?

THE CHAIRMAN: Yes.

MR PEARCE: It occurs to me -- I have a copy in front of me which I have annotated, but it then occurred to me that your learned Legal Assessor may not have one. So, I can only refer to certain page references and either we will arrange to serve a copy to come to you, or as the case may be.

But, sir, in my submission each of their Lordships in the case of *ex parte Bennett* in the majority made clear that they were dealing with executive action and not any other forms of misconduct. And I should say that of the five Lordships in the House Lord Oliver dissented in any event and felt they had no jurisdiction.

So, if we put his Judgment aside, for the other four Lordships I shall simply give you relevant page references if I may, sir. In the case of Lord Griffiths it is -- and this is, I should say, the Weekly Law Reports for 1993, Volume 3, Page 90. Lord Griffiths deals with this issue on Page 104 at Paragraphs E to F and Lord Bridge deals with the position at Paragraph 110 Letter A. In Lord Bridge's case, but not in the case of the rest of the majority in the House of Lords, it appears to be the case that he was limiting the abuse even more narrowly to executive action outside of the United Kingdom within the territorial jurisdiction of another country, but he is in the minority of one I think on so limiting it.

Lord Lowry, at Page 119 F, again indicates that the Court "... must jealously protect its process from misuse by the executive", which words he highlights, and then finally Lord Slynn in one of those one-paragraph Judgments where he agrees with everybody else clearly agrees with what the majority have to say and in particular adopts the speeches of Lord Griffiths. So, in my submission that principle is limited to the misuse of power by the executive.

THE LEGAL ASSESSOR: Thank you.

MR MORRIS: Now, sir, may I respond to the submissions of my learned friend and start off with Head of Charge 6 and the two options which he quite accurately spelled out as to: (1) whether the first case that I made was that there were two different people, or two different authors for the letters at 1996 and the letters of 2000 onwards; or, if that was not right, there was the alternative proposition that I put forward that the author was one and the same person.

And I think it was in the context of that latter proposition that Mr Pearce said that, if that is right, you have this scenario that you have the mother who is at first not complaining and being manipulated by Mr Daniels on behalf of the Commission inasmuch as he is putting in documents on her behalf without her authority, but now in 2004 you have the good lady coming here to say, "But I do support the complaint. I do adopt the complaint", and he says to you, "That is madness to make such a proposition".

Well in an ideal world it would be madness, but I am afraid that in relation to the Head of
Charge we are not in an ideal world. We are in a world that is coloured by the attitude and approaches and procedures of the Church of Scientology and I say on behalf of Dr Cosgrove that, if you look at the evidence here, it is not a mad proposition to make.

Look at the difference in the tone of the letters that were written, if we are assuming that this is the same person, in 1996, and the manner and tone in which that person - that author - gave evidence before you in 2004. There could not be a starker difference. In 1996 she was writing gratefully to Dr Cosgrove saying that, "Were it not for you, Doctor ..." -- I am not quoting her accurately, but the substance is correct. "Were it not for you, Doctor, I am sure that my child now would be in care", whereas now we have put forward in strident tones all the criticisms that, in my submission, have all the hallmarks of the concerns of the Commission of Scientologists.

I suggest she has been suborned, corrupted by the Commission. That is not a mad proposition. That is what Scientologists do. Do not take my word for it. In the Foster Report Mr Foster made reference to the Anderson Inquiry. You will recall that that was the Inquiry that took place in the State of Victoria a few years before the Foster Inquiry was set up. It is detailed at paragraph 17 of the report. Mr Anderson is described by Mr Foster,

"Mr Kevin Victor Anderson, Q.C., a distinguished leader of the Melbourne Bar, who has since been elevated to the Victorian Supreme Court Bench."

He chaired the Inquiry. You may think, unlike any other Inquiry into Scientology and its practices, this was an Inquiry where all parties took an active part, those against, those in favour and the Church itself took an active part in the proceedings. They were all represented by Solicitors and Counsel. They were all available to give evidence on oath with cross-examination of witnesses. The evidence was given in public. I am looking at paragraph 18. I will be corrected if it I am wrong, but also significantly it was the only Inquiry in which Scientologists, and they later felt this was a big mistake, agreed to take part in this full and frank way.

The thoroughness of the Inquiry is set out at paragraph 19 and the conclusions drawn by Mr Anderson in his report at the conclusion of this very thorough Inquiry of 160 days, 151 witnesses, many millions of words given in evidence, proved to be wholly unfavourable to Scientology.

"Scientology is evil; its techniques evil; its practice a serious threat to the community, medically, morally and socially, and its adherents sadly deluded and often mentally ill.

(10) Scientology is a fabric of falsehood, fraud and fantasy."

That is not someone shooting from the hip. That is the considered conclusion of Mr Anderson at the end of that Inquiry. I am afraid this is the nature of the beast you are dealing with. That is why I suggest that it is not madness to make that proposition.

If I am right and the name of your panel member who stood down has been put on to the names of the letterhead of the Commission as someone who is clearly senior, active and
centrally involved in that Commission when that is not the truth, that speaks volumes for
the nature of the organisation with whom Mrs D got involved.

My learned friend sought to defend Mrs D from any allegations of dishonesty. Of course,
it is a matter for you and you have to make up your own minds. He tells you that the
manner she gave evidence and the way she dealt with cross-examination showed only that
she was an honest witness. I regretfully have to dispute that submission. The evidence of
her dishonesty is perhaps most obvious just from two documents. They are D6 and D2.
They are the letter of complaint which she said she wrote out in manuscript and had typed
by Mr Daniels, and D2, the letter of authority giving consent for the disclosure of her
son’s medical records which she said she wrote out in manuscript and got a near
neighbour to type up. In my submission, that cannot be correct if you look at the form of
those two letters and the heading, and the fact that in both those letters her name,
apparently if she is right, copied incorrectly by two different people, one her neighbour
and one Mr Daniels when typing out her manuscript.

That is a telling piece of evidence, in my submission, which tells you that she has come
here with every intention, not of telling the truth but of hiding the degree of involvement
by the Commission in the complaint that she now seeks to assert is hers and effectively
hers alone. That is my answer to the rhetorical question my learned friend asked you in
his submissions: where is the evidence in this case of orchestration of complaint?

Can I turn to the breach of promise issues and can I deal with them globally, inasmuch as
they both concern the effect of head of charge 6 and as they stand as a freestanding head
of abuse. Mr Pearce says this is just a technical point that has occurred to those advising
Dr Cosgrove in the last few days, indeed over the weekend. It has no merit for that
reason, because if it had any merit you would expect Dr Cosgrove when he received his
rule 6 letter to screaming from the roof tops. It is a novel proposition, in my submission,
that an abuse of process only becomes an abuse of process if the victim of it complains.
If he remains silent there is no abuse. I do not accept that for one moment on the part of
Dr Cosgrove, who you have not heard from and we have here a doctor who has been
notified of complaints sometimes up to three years before that letter was written. When
the letter is duly written on 1 October 2002 who is to say what his reaction should be?
Who is to say what his knowledge of the law of abuse of process might be and whether or
not he felt entitled to make any complaint of the fact that after three years he was being
sent down the conduct route?

Can I deal with the factual matters in relation to additional matters of complaint or
information that may have come in to the Council subsequent to the decisions made by
the first screener or screeners in which cases were sent down the performance route? My
learned friend relied on a new document, C6. Can I put in a further memorandum which
was in the bundle disclosed last week and the Committee have not seen? Of course, I
appreciate I should not be putting in new documentation at this time. If my learned friend
wishes to make further submissions on it I shall not stand in his way.

THE CHAIRMAN: This will be D26.

MR MORRIS: This is a memorandum from Mr Lynn to the screener, Dr Malcolm Lewis,
dated 12 September 2002, first of all, dealing with the proposed heads in the proposed
rule 6 letter. Can I take you to paragraph 3, which hopefully will begin to fill in some of
the gaps you might be wondering about in the Cosgrove open cases list which I would
invite you to turn up. It is the table at D22. Paragraph 3,

“I would be grateful if you could confirm your approval of the revised allegations
and also to sign off the SDFs which I have attached to the front of the appropriate
files. There are only seven files as I have removed the latest file which you
declared an interest in and suggested that we need to make further inquiries, and
the three closed cases which were complaints from Dr Cosgrove…”

not about Dr Cosgrove,

“…have similarly been removed because no allegations arise from those cases and
they are in any event already closed. These seven files are therefore the ones
where screening decisions had to be taken. You might find the following of some
help, but of course your decision and the reasons for it is entirely a matter for
you.”

Then we have 1997/1376 SDF 04. If you look at the table you will see that reference and
that is the very first reference. It is the Home Office drugs reference. It goes on to say,

“Referral by Home Office. Field Fisher Waterhouse. This is not going forward to
PPC. I think this would have to be on the grounds that there is no probative
evidence to suggest that Dr Cosgrove has prescribed irresponsible for the reasons
we have talked about and which Peter Steele outlined in his advice.”

So there is nothing there by way of further information justifying any change in the
previous stance of the Council. Then we have SDF 06, which I think again refers to the
Dr Holme complaint.

“Complaint from Dr Holme. This is going forward to PPC.”

In manuscript then 2000/0871. That we see is the next box down. That is the
Pembrokeshire and Derwen NHS Trust going forward to PPC. 2003/017. That is the
Oxfordshire Mental Health Care NHS Trust going forward to PPC. 2001/1711. That is
the Commission’s case. SDF 01.

“This case I believe from the FPD system is about…”

A name of a patient is given. Indeed, it seems that the patient’s mother’s name appears in
the box over the page on the table.

“This case is not going forward. Again, I think it would have to be on the basis
that there is no probative evidence that Dr Cosgrove’s prescribing in itself was
serious professional misconduct.”

So, again, there is no fresh information there justifying a change by the Council. SDF 02
is the case of, and I think this clearly is a reference to patient D, which is going forward
to PPC. 2000/1390 is Dr Karen Moses, Gwent Health Care NHS Trust. You can see the
reference on the table.

“This is going forward to PPC.”

2000/3359 is Helen Chubb of Cardiff and Vale,

“This is going forward to PPC.”

2002/1505, which is one of the cases raised by my learned friend as possibly being new material, SDF 01 and SDF 02. We have that. That is the final box on the table.

“Referrals from Home Office and West Yorkshire Police. Neither of these are going forward to PPC. Again, I think this would have to be on the basis of no probative evidence of Dr Cosgrove’s prescribing in itself being serious professional misconduct.”

That, I hope, fills in some of the lacunae in that table and does not disclose anywhere further information or complaints that could possibly be said to amount to or raise a question of serious professional misconduct.

Then we have the other matter that was raised out of C6, which is the other memorandum from Mr Lynn to Dr Lewis of 5 September 2002, where there was one other matter and that is at paragraph 3, 2003/1616, which has not made it on to the table of the open cases list. Again, we see here that concerns are raised about that and that is put forward to the screener. That is a case that came in. I am not sure when it came in. I am not sure a date is put there, but it appears to be a fairly recent case. It certainly did no get on to that table. We know that it did not feature in the rule 6 letter and it does not feature in the matters before you. In my submission, one can infer from that that when it went before the screener, presumably Dr Malcolm Lewis, it was not put forward by him to be added to the list.

There is nothing in the documentation, in my submission, that amounts to any additional matters being available to the Council over and above those matters that were already there and available to the first screener or screeners when they saw these complaints. That is an important point and premise when one comes to consider the significance of what happened here.

What you have got here, in my submission, is the Council through one screener looking at these cases and saying some of them should go down the performance route, and in relation to others no positive recommendation that they go down the conduct route.

Mr Pearce says on behalf of the Council that there is no evidence of bad faith here on the part of the General Medical Council. Well, I make a number of points on that and the first one is a legal point which, in my submission, is that you do not need to have bad faith before finding such a breach of promise an abuse of process.

If you look at the Dean case, D23, I will just refer you to a passage which clearly bears repeating because, although I have cited it once, I am not sure it has sunk home in certain quarters. If we look at page 82 – and this I said was one of the leading cases in relation to
breach of promise – under the heading “Abuse of Process” Lord Justice Staughton about half-way down there, referred to the submission made by the prosecuting counsel in that case that you needed to have either delay or manipulation or misuse of the rules of procedure but Lord Justice Staughton took the view and the judgement stated such, that there was authority that the concept was wider than that and he cited a House of Lords case in which Lord Diplock said:

“The inherent power which any court of justice must possess to prevent misuse of its procedure in a way which, although not inconsistent with the literal application of its procedural rules, would nevertheless be manifestly unfair to a party to litigation before it would otherwise bring the administration of justice into disrepute among right-thinking people. The circumstances in which abuse of process can arise are very varied.”

So it is not necessary to establish a manipulation or misuse of the rules of procedure. To that extent and in that context it is not necessary to establish bad faith. At the end of his judgment over the page:

“In my judgment the prosecution of a person who has received a promise, undertaking or representation from the police that he will not be prosecuted is capable of being an abuse of process. Mr Collins was eventually disposed to concede as much providing (i) that the promisor had power to decide and (ii) that the case was one of bad faith or something akin to that. I do not accept either of those requirements is essential.”

What we have here, then, is a case where these cases were put before a screener and that screener decided they should go down the performance route. Without any further information or relevant information or complaint, Dr Lewis in February 2002 has the complaints back before him. He looks at them and decides no, this is going to conduct.

Now my learned friend in discussion with the learned Legal Assessor said that this cannot possibly approach within kilometres the threshold for amounting to abuse. There is no breach of any rule either within the conduct Committee rules or the performance Committee rules here. Again, I take you to the passage from Lord Diplock which says, “There can be abuse even though what has happened is not inconsistent with the literal application of its procedural rules.”

The logic of what my learned friend is saying is this. He is saying that it is quite in order for the General Medical Council through it screeners to say, “Right, we have got a set of complaints. One medical screener says it is performance. We will put it back before another medical screener and see what he says and if we get conduct then so be it, we will send it down the conduct route.” The logic of that is this; there would be nothing wrong if Dr Lewis had said, “No, I agree with the first screener, these matters ought to go down the performance route.” There would be nothing wrong for the council to say, “We will put it in front of a third, different, medical screener and see what he or she says” and so on and so on until somebody says, “We suggest this should go down the conduct route.” That is the logic of what he is saying.
In my submission when you look at it in that rather extreme form you can see quite clearly why this process can amount to an abuse. My submission is that in the absence of any explanation before you as to why those matters came back to a screener, one can only infer that something very wrong with the process has occurred.

This is not a situation, as in the case of Murphy where, in a different court at a different time – at a very different time – a different view was taken in relation to an indecent assault charge. We are at the very same stage. Nothing has moved on. We are at the screening stage. Why did it have to come back to the screener when there was nothing new, no change of circumstance?

It is quite clear in my submission from what has been disclosed that the powers that be within the General Medical Council felt thoroughly uncomfortable with what had happened and you will recall I took you through the memoranda where numerous personnel sought to think why it might be or how it might be that they could justify the appearance of these matters before another screener and a different view being obtained. Throughout it is the suggestion, “There is further information coming in.” No indication in Dr Lewis’ memo at the end of February of any such information. He says at paragraph 7:

“In this case the doctor has been previously informed that this case would not progress under the conduct procedures. However, cases that have come to light since would enable this case to be resurrected under the appropriate clause.”

There are no such cases, if you look at the table, nor has my learned friend sought to identify any such cases. It goes on with other personnel there talking about the need to seek legal advice. Most extraordinary of all, in my submission, the legal advice that was eventually given by Mr Steel on 30 August. He was quite open, frankly, about the position. Under paragraph 1, performance conduct:

“It appears that all the files were reviewed by Malcolm Lewis on 27 February who screened them all down the conduct route despite the fact that some had already been screened down the performance route. Dr Cosgrove had been informed that this was the case. I have discussed this with Paul who is of the view that on policy grounds alone we cannot go behind this decision regardless of whether it was correct in law to do so. It may in fact have been legitimate for the screener to say that in the light of the further complaints this case was better dealt with down the conduct route but that is perhaps an academic debate.”

There were no further complaints and it is not an academic complaint. If there are no further complaints we are left with a huge vacuum which the Council cannot fill as to what possible legitimate reason was there for putting that matter back before Dr Lewis?

My learned friend went on to deal with the question of non-disclosure of information. He said to what issues did the matters or the material that was sought go. It has been clear since the beginning of last week that an abuse argument was being run and disclosure has been made. It is the duty of the prosecuting authorities to review all the material that they
have in their possession and to see whether any of it may assist in the defence case as it is made known to them.

There has been no indication – and of course I will be corrected if I am wrong and I will accept that, of course, from my learned friend but there has been no indication – that the Council has reviewed the original screener’s memoranda to see whether or not there is material in there that may or may not assist the defence in the case they seek to put and it is not right, in my submission, to describe the request for those memoranda as a “fishing expedition.”

The Council have an obligation to review that. The Council have disclosed the subsequent screener’s letter. The original screener’s letter or memoranda must give reasons why it is that in the view of a medical person it is right that these matters do not go down conduct but do go down performance.

It followed, I would have thought, as a matter of pure logic that that material must be relevant to the defence of this case, which is that this doctor is not guilty of serious professional misconduct.

My learned friend says that in relation to Head of Charge 6 if Mrs D is guilty of fraud, then there is a cast iron defence to that and that can be properly dealt with by the trial process where the truth will out. That is indubitably right but the whole point about an abuse of process argument and the jurisdiction that allows abuse of process to be argued, that there are certain sets of circumstances where it would be wholly wrong to put a defendant at risk in any way of being found guilty of a substantive charge if the process by which that charge came to be brought has wholly been subverted by the prosecuting parties or the people who complain to the prosecuting party.

My learned friend cited the case of *A Health Authority v X* and I wholly agree with the point made there that it is of overriding importance that the disciplinary process should take place if appropriate – the words my learned friend cited. Of course, that is right. So it should be that murder trials take place if appropriate and, again, that caveat, “if appropriate”, is the important quotation here. Even the most serious of allegations can be stopped from being heard if the process by which they came to be put in train has been so corrupted as to amount to an abuse of the process of the trial procedure.

Can I deal finally with the Head of Charge 2 submission. My learned friend said that he of course accepted that the parents had not given their consent. It is my fault if he has not been shown the basis upon which we say that. Could I circulate the relevant document?

THE CHAIRMAN: This will be D27. *(Produced)*

MR MORRIS: I have the original letter that was sent by Radcliffes le Brasseur to the parents dated 5 November here and the original endorsement at the bottom, which his signed by the patient’s father and says:

“We regard our son’s medical files as strictly confidential and do not agree to the release of such information to your firm or to other people connected with the GMC hearing.”
it is signed on 18 November 2003 and if the Committee wish to see the original it is here available for them.

My learned friend asks really whether or not the notes are going to help here in relation to the issue that appears to be between the parties here as to whether or not Dr Holmes was asked to monitor. The answer to such an issue, in my submission, clearly the Committee would be helped in deciding such a factual dispute, in my submission, by the contemporaneous notes of both parties where one might, you would think, get some very cogent assistance as to who made the request for monitoring, what form of monitoring was done by either Dr Cosgrove or Dr Holmes and whether or not there was any communication between the two noted in either sets of notes.

I of course accept that, if this Committee feels that it would be right to admit those notes, it has the power given to it by the Rules to admit into evidence such notes. Notwithstanding the refusal of consent by the parents I accept that they have that power, and all I would say is that at present that power has not been exercised and at present the Doctor could not receive a fair trial on the issues raised in Head of Charge 2 without being able to look at and consult the relevant notes.

And I would invite, if this is what the Committee has in mind and feels it would be right to override the consent of the parents, the Committee to make that clear now in its determination in relation to these various issues so that steps could be put in train for the notes to be made available in advance of any substantive hearing if there is going to be a substantive hearing.

Those are the submissions I make.

THE LEGAL ASSESSOR: Just very briefly, Mr Morris, I fear one of the places where it did not quite sink in as regards Bennett and the case of Hunter was with me. I apologise if that is the case, but could I just very briefly refer you to the case of R -v- Croydon Justices, ex parte Dean. You took us to the passage on D23, Page 82, and I just want to make sure that I have understood this correctly.

You referred us to the passage which Lord Diplock said in the case of Hunter -v- Chief Constable of the West Midlands Police [1982]. Have I understood you correctly that is your submission to this Committee that, applying if you like a definition of abuse of process as being reflected in that passage, that if I substitute the word "Committee" for "Court":

"the inherent power which any ..." (Committee) "... must possess to prevent misuse of its procedure in a way which, although not inconsistent with the literal application of its procedural rules, would nevertheless be manifestly unfair to a party to litigation before it, or would otherwise bring the administration of justice into disrepute among right-thinking people",

is it your submission that what happened procedurally in Dr Cosgrove's case amounts to
an abuse within that definition or description of the abuse of process?

MR MORRIS: Yes, it is.

THE LEGAL ASSESSOR: Yes. I just wondered because, as I understood Mr Pearce, he was saying as I understand him that his submission was that it could not possibly -- what happened procedurally in this case could not possibly meet that test but, as I understand you, you are saying, "No, that is wrong. It does fall within that test".

MR MORRIS: Yes.

THE LEGAL ASSESSOR: Thank you. Okay, I am grateful.

MR MORRIS: Yes. And I gave the rather extreme example where if this matter had gone back not just to the second screener, but to a third, fourth and fifth screener. I hope that makes it clear.

THE LEGAL ASSESSOR: And just so I have clearly understood, if the Committee is minded to say that they use their power under Rule 50 in relation to the medical records, which are relevant to Count 2 I think it was, then that would solve any difficulty provided they exercised their power now?

MR MORRIS: Yes, because I could not submit that the Doctor was unable to have a fair trial on that Head. That is assuming that the earlier submissions have failed.

THE LEGAL ASSESSOR: Absolutely, yes.

MR MORRIS: Yes.

THE LEGAL ASSESSOR: And then just lastly, if they were not minded to consider to exercise their power under Rule 50 then a different set of circumstances would apply?

MR MORRIS: Then my submission would remain.

THE LEGAL ASSESSOR: Yes, thank you very much indeed. Thank you.

THE CHAIRMAN: Well, I think that has brought us to the end of the submissions and it has brought us to the end of the proceedings for today. We shall reconvene hopefully at 9:30 tomorrow and, with a bit of luck, the Legal Assessor will be able to give his advice before we go into camera.

Thank you very much.

(The Committee adjourned until Tuesday, 27 January 2004 at 9:30 a.m.)
GENERAL MEDICAL COUNCIL

PROFESSIONAL CONDUCT COMMITTEE

On:
Tuesday, 27 January 2004

Held at:
Barnett House
53 Fountain Street
Manchester M2 2AN

Case of:

PATRICK VERNON FINN COSGROVE MB BS 1968 Lond
(Day Five)

Committee Members:
Professor Norman Mackay (Chairman)
Dr Alison Hamilton
Mr John Matharu
Dr Belinda Stanley
Mr Richard Briden (Legal Assessor)

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MR D MORRIS, of Counsel, instructed by Messrs RadcliffesLeBrasseur, appeared on behalf of Dr Cosgrove, who was present.

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

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(Transcript of the shorthand notes of TranscribeUK
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THE CHAIRMAN: Good morning. Before I ask the Legal Assessor to tender his advice I would wish to report that following on from a letter which was submitted to the Panel yesterday, D17, the question was raised as to whether the Christopher Brightmore whose name featured in the left hand side of that page was the same person who originally started on this Panel on Monday of last week. As you recall, Mr Brightmore stood down.

Last night I had a telephone call from Mr Brightmore and he confirms that he is one and the same person who features on this letter. He was a Commissioner of the Citizens Commission on Human Rights, but he informs me that he resigned that position on 1 January 2001. This letter is dated 28 March 2001 and the explanation that was given to me was that his name featured on that document, because the Commission was using up old notepaper, but that his name has been removed from it subsequently. It does not alter the fact that he was a Commissioner on the Citizens Commission on Human Rights. That piece of information was not known to us last week when he stood down.

I thought in the circumstances that, as Mr Morris was raising questions as to whether the name Brightmore was the same Mr Brightmore as sat on our Panel and whether his name appeared on that letterhead with his knowledge and permission, I should certainly share it with you all today. Mr Morris.

MR MORRIS: Sir, I am very grateful for that information. I was given it by the learned Legal Assessor a little in advance of our sitting, so I have had an opportunity to discuss it with Dr Cosgrove. There are three small points I wish to make. The Chairman is quite right in saying that at D17 there is a letter dated 28 March which still carries Mr Brightmore’s name on the letterhead. There is also a later letter of 9 May in D17, which also has his name on it, so it does appear that five months after his resignation the Commission was still using outdated letterhead paper.

The second point is that it is a matter of regret, as far as the defence of Dr Cosgrove are concerned, that this information was not made known at the outset of this hearing when the possibility of the involvement of members of the Committee with Scientology or in any connection with Scientology was raised, because obviously, had I known that, I would not have made the submission in relation to Mr Brightmore that I did yesterday. I obviously must withdraw the suggestion that I made yesterday that if Mr Brightmore was correct in what he disclosed to us at the outset, then this was a serious misrepresentation on the part of the Commission to include his name as one of their Commissioners. Clearly, the Commission cannot be criticised for that and I withdraw that.

Nevertheless, my overall submissions about the Commission remain and I made the submission I did about Mr Brightmore very much as a footnote to those submissions. I remind the Committee that I also submitted that the Commission had been guilty of misrepresenting Professor Roth leading to defamation action, and that generally they were imbued with the Scientology approach to psychiatry as set out in the Foster Report, and indeed confirmed by way of up to date approach by exhibit D16, the front of the current website, where psychiatry is equated with misappropriation, pretended authority, betrayal, raft, abuse and greed. I am very grateful to the Committee for raising that.

THE CHAIRMAN: Mr Pearce.
MR PEARCE: Sir, we are grateful for you raising the point. We have nothing to add to what is being said.

THE CHAIRMAN: Thank you very much. At this point I will turn to the Legal Assessor for his advice.

THE LEGAL ASSESSOR: I have written my advice down. I propose to read it to you as it is in draft. The reason for this is that the draft can then be taken with the Committee into its deliberations and can be referred to, should they need reminding of the advice. Of course, if any new advice is given in the course of deliberations the parties will be informed of that.

My advice is as follows: Mr Morris wishes to make an application to stay these proceedings on the ground that their prosecution amounts to an abuse of the process. He does so in relation to the entirety of the charges and in relation to specific charges. What is an abuse of the process? One looks in vain for a comprehensive definition in the authorities and in the case law. In order to hopefully provide guidance to the Committee I propose to adopt and then attempt to adapt the circumstances of a GMC disciplinary hearing the words of Lord Diplock in the case of Hunter v Chief Constable of the West Midlands Police. I pause there to say that that is a House of Lords authority, as quoted in R v Croydon Justices, ex parte Dean, which the Committee has at page 82 of D23.

The result of this attempt and adaptation is as follows. An abuse of the process occurs when there is a misuse of the GMC disciplinary procedures in a way which, although not necessarily inconsistent with the literal application of its procedural rules, results in manifest unfairness to the practitioner or otherwise brings the administration of justice through the disciplinary process into disrepute in the view of right thinking persons. The circumstances in which such an abuse can arise are very varied. I stress that last sentence and repeat: the circumstances in which such an abuse can arise are very varied.

This is the nearest, in my opinion, that I can get to a working definition and I think it important to add a number of points of general application. Firstly, if the effect of the continued prosecution of the charges is one of manifest unfairness to the practitioner or that the administration of professional justice is brought into disrepute, then it matters not that there has been a failure to demonstrate bad faith, or conscious manipulation of the procedures by the prosecution. This I take from the case of ex parte Dean, which is at D23.

Secondly, in determining whether an abuse is established, the Committee may have regard to how far any unfairness to the practitioner or bringing into disrepute of the system may be cured by the actual trial process and/or the exercise of the other powers available to it. The Committee will have regard to the pressing public interest in having disciplinary hearings determined on their merits and should proceed to do so, save in cases in which an abuse is duly proved to them.

Thirdly, it is for the practitioner to prove such an abuse. The standard of proof required of him is that he proves his case on the balance of probabilities, i.e. is it more likely than not that the continued prosecution of the charges under attack amounts to an abuse of the process? The standard of proof is a simple tipping of the balance of probabilities and is
not a heavy or enhanced balance of probabilities, i.e. one just falling short of the criminal standard which is sometimes utilised in civil cases involving fraud.

Fourthly, the Committee should take into account all the evidence before it and consider all the submissions made by counsel. The weight you attach to any piece of evidence is a matter for you, the Committee. What reasonable inferences you draw from the evidence is also a matter for you. What you cannot do, however, is ignore any of the evidence before you. Once you have considered it, however, the weight that you attach to it is exclusively a matter for you.

That is the general advice on law that I want to give. I am not going to go through all the evidence and counsel’s submissions. However, there are a number of specific points I feel call for advice. In relation to count 6 you are asked to find that in reality the complainant is an agent of the Church of Scientology Commission who have suborned and corrupted the witness (who I shall refer to as Mrs D) into supporting the complaint and thereby taking part in the orchestrated campaign that the Church of Scientology is said to conduct against practitioners such as Dr Cosgrove. Whether you find this proved and that it results in what amounts to an abuse of the process is a matter for you. As indicated, you must take into account all the evidence and Mrs D’s evidence is clearly material to this particular charge. It is important that you consider the inconsistencies that Mr Morris has pointed out about her evidence; for example, the venue of her consultation with Dr Cosgrove (was it Bristol or was it Bath?) If you consider these significant (and that is a matter for you) this may affect the weight you attach to her evidence. On the other hand, where her evidence is consistent with other evidence it may enhance her credibility. Again, I stress it is ultimately a matter for you what weight you place on her evidence, but you must consider the submissions of counsel as to the inconsistency or otherwise of her evidence.

The attack on count 6 broadens into an attack on all the charges on the basis (and I will try and put this shortly) that the abuse on count 6 taken with the overall manner in which the procedures were followed in Dr Cosgrove’s case have the knock on effect of making the prosecution of all charges against him an abuse. Again, it is a question of fact for you to decide whether this has been proved to the required standard, taking into account all the evidence before you and the submissions made on them by learned counsel.

However, there are three matters on which I want to give specific advice. Firstly, insofar as it is submitted by Mr Pearce for the GMC that Dr Cosgrove’s failure to complain until this hearing about the change in how some of the complaints against him were dealt with (i.e. they were removed from the procedures relating to an assessment of his professional performance and considered under ones which focused on his professional conduct) that these prevent such a charge from ever being considered abusive I respectfully disagree. Insofar as it is submitted that such a failure to complain necessarily points to an absence of there being an abuse, again I have to respectfully disagree.

The time when any complaint about such a change is made is indeed in evidence before you and may assist the Committee in its deliberations, as may any evidence, but whether an abuse is proved is not determined by the subjective reaction of a practitioner to the facts which are said to constitute the abuse, but by an objective assessment as to the evidence relating to the effect of those facts.
Secondly, it has been submitted by Mr Pearce for the GMC that the delay in dealing with some of the complaints against Dr Cosgrove, taken with the communication to him of the decision which was subsequently reversed, that some of the complaints would be dealt with under the performance procedures cannot amount in law to an abuse. Again, I have to say I respectfully disagree with that view. My advice is that it is a question of fact for you, the Committee, to decide whether or not the procedural career of Dr Cosgrove’s case meets the threshold requirements of what constitutes an abuse and that it would be open to you to decide that such a threshold has been met.

Let me be abundantly clear here. I am not for one moment suggesting that you make that finding. I am not attempting by implication, express or subliminal, to point you in that direction. What I am simply saying is that it is a decision which is open to you on the evidence.

Thirdly, there has been considerable discussion about the significance of whether or not what has happened procedurally (and I use the word widely to describe the whole procedural career of this case) amounts to a breach of Dr Cosgrove’s legitimate expectations. I have thought long and hard about this and my opinion is that this is only relevant to the question of whether or not had the General Medical Council been challenged earlier in the administrative court any of its decisions would have been quashed by that court. Breach of a legitimate expectation is a fact sensitive test which the High Court applies when judicially reviewing the actions of public bodies. The same facts which may have persuaded the administrative court to grant judicial review may or may not amount to conduct which this Committee finds amounts to an abuse of the process. The test to be applied to the facts of this case by this Committee is not the test used by the administrative court, but, I advise, that which is found in the dictum of Lord Diplock in *Hunter v. Chief Constable* which I have quoted earlier and which appears at D23, even though the two tests may ultimately lead to the same result.

The question, in my opinion, ultimately is: Has what has happened here been proved to be an abuse? I stress that that is a factual question for you to decide.

Lastly, I turn to Mr Morris’s submission on Count 2 in relation to Patient A who is a minor, that the refusal of Patient A’s parents to consent to the release of his medical records to the Committee prejudices his case. My advice is that as the records are contemporaneous records of facts, at least in issue, if not in dispute, they are, I suggest, clearly relevant and although it is a question of fact for yourselves you may find that their non disclosure would prejudice Dr Cosgrove such that the continuation of Count 2 would result in manifest unfairness to him and it would, therefore, be abusive to continue with that count, although I do stress ultimately it is a matter for you to decide.

Both counsel appear to be in agreement that one solution is by the application of Rule 50 to override the consent of Patient’s A’s parents. I agree subject to this. Before you can take that route you would have to be satisfied that the pressing public interest in Dr Cosgrove having a fair resolution of the complaints against him outweighs the right of Patient A to have his confidentiality respected, particularly as he is a minor. Once again, this is a factual question for yourselves. You may, of course, take into account any procedural powers you have, such as the ability of the Committee to sit in camera which may allow the Committee to receive the medical records whilst at least in part preserving
Patient A’s confidentiality. That is my advice.

THE CHAIRMAN: I turn to Mr Pearce and Mr Morris. Mr Morris, do you want to pass any comment?

MR MORRIS: Sir, may I just raise one slight query and it may be that I have misheard what the learned Legal Assessor has said. It is in relation to his general remarks at the outset as to abuse of process where he made the remark that the Committee may have regard to how far any unfairness can be remedied by the trial process itself. I hope that was not said (and I do not think it was, and I just want to clarify) to suggest that in relation to any sort of unfairness which is found the Committee can then consider whether or not that can be cured during the trial process before coming to a decision on abuse, because, in my submission, Archbold makes clear that there are two types of abuse, abuse which makes the trial process unfair or abuse such that it would be unfair to have a trial even though the trial process itself might be fair.

LEGAL ASSESSOR: I am grateful for that. Can I just not answer you directly, but say it this way. I have tried to structure my advice by looking in the cases for what comes closest to a general definition of what constitutes an abuse of process. I have tried to avoid going into the distinctions, as you say, between those which make a trial unfair and those which for any other reasons mean it should not go ahead. The definition I have tried to put before the Committee which, in my opinion, is the most workable one, is what is the effect of what has happened, does it result in manifest unfairness to the practitioner or does it otherwise bring the procedures into disrepute? I have tried to go down that route.

What I am saying is that in considering whether or not manifest unfairness is made out against the practitioner, they can have regard to, not determination, but regard to the fact that the trial processes have certain procedures, the existence of which prevent manifest unfairness arising in the first place. I am sorry I cannot answer your question directly, because you posit a definition of abuse which I have avoided.

MR MORRIS: I think I can use the definition that you have used, which is an adoption of the words of Lord Diplock, just to make the point I wish to make about the advice you have tendered, where he says:

“The inherent power which any Court of Justice must possess to prevent misuse of its procedure in a way which, although not inconsistent with the literal application of its procedural rules, would nevertheless be manifestly unfair to a party to litigation before it or would otherwise bring the administration of justice into disrepute among right-thinking people.”

All I am trying to clarify as to the advice that you are giving, is to make the suggestion that there can be circumstances – for example breach of promise that I have submitted in this case – whereby if there were such a breach of promise and a trial proceeded, the trial process itself could be perfectly fair but that because the breach of promise is such that to allow the proceedings to continue would amount to bringing the administration of justice into disrepute, then abuse is established.
THE LEGAL ASSESSOR: Can I say it this way. The way I would try and square that particular legal circle is that in those circumstances – breach of promise – the Committee can take that into account. They may find that that persuades them there is manifest unfairness.

MR MORRIS: Very well.

THE LEGAL ASSESSOR: Perhaps I can do it this way. I understand your concerns and I am most anxious that Dr Cosgrove has a fair hearing on this. I will just read again the actual adaptation that I am trying to use:

“An abuse of the process occurs when there is a misuse of the GMC disciplinary procedures in a way which, although not necessarily inconsistent with the literal application of its procedural rules, results in manifest unfairness to the practitioner.”

There that stands alone.

MR MORRIS: The only gloss I wish to add is that there are circumstances when nothing within the trial process would be able to cure such manifest unfairness.

THE LEGAL ASSESSOR: Then that would amount, in the context of my advice, to manifest unfairness. I have attempted – can I say this – to trek through the authorities to try and identify a short workable definition. I am grateful for the gloss. I think the gloss is included there in the advice, in the words “manifest unfairness.”

MR MORRIS: I am grateful for that clarification. Thank you.

THE CHAIRMAN: At this point the Panel will go into camera and strangers will withdraw.

STRANGERS THEN, BY DIRECTION FROM THE CHAIR WITHDRAWED
AND THE PANEL DELIBERATED IN CAMERA

STRANGERS HAVING BEEN READMITTED

THE CHAIRMAN: Mr Morris, the Committee have considered your request under rule 24 (2) to stay proceedings against Dr Cosgrove on the grounds of an abuse of process. They have carefully considered the submissions made by you and Mr Pearce, Counsel for the GMC and the comprehensive advice tendered by the Legal Assessor, which the Committee have followed.

The application has been made on the grounds that to allow the hearing of these charges to proceed would be an abuse of process. There are three separate submissions on which the applications to stay these proceedings are based, namely...
• a fraudulent or manipulative complaint being made to the GMC with regard to Head 6 and the effect that complaint had on bringing the other complaints before the Professional Conduct Committee;

• Legitimate expectation, breach of promise and bad faith on Heads of Charge 2, 3, 4, 5, 6, 7, 8, and 9 and the effect of those Heads of Charge being redirected into conduct on Heads 10 and 11 being referred to the Professional Conduct Committee. In addition the Committee have considered the concerns raised about the non-disclosure of internal GMC documents surrounding the initial screening process;

• The third issue is the disclosure of documentation in relation to Head of Charge 2.

The first submission is that Head of Charge 6 concerning Master D was based on information submitted to the GMC in a letter dated 18 August 2000, purporting to come from Mrs D. It is your contention that this letter came from an organisation named “The Citizens’ Commission on Human Rights” (CCHR) which was established in 1969 by the Church of Scientology to investigate and expose psychiatrists’ breaches of human rights and that information forwarded to the GMC by the CCHR is fraudulent.

The Committee have heard evidence from Mrs D on oath that whilst the letter of 18 August 2000 outlining the complaint was unsigned and was typed by the CCHR, it had been drafted by her and she accepted ownership of it.

The Committee have also heard evidence from Mrs D that it is her signature which is present on other documents being considered by the Committee and have heard and accepted her explanation for the inconsistencies in the spelling of her name. They have also heard evidence from a handwriting expert who gave the opinion that the signatures given in the name of Mrs D on a variety of documents are probably all written by the same person.

Mrs D in her evidence was adamant that the signatures were hers. Despite inconsistencies in Mrs D’s witness statement as to where she consulted Dr Cosgrove, the Committee accept that her evidence is credible and reliable and, although the letter of 18 August 2000 is not signed by her, they consider that she has ownership of the complaint and that the complaint is not fraudulent.

Mrs D acknowledges that she obtained advice and assistance from “Overload” and Mr Daniels from CCHR, but the Committee do not consider this to be inappropriate. The Committee have determined that there has not been an abuse of process in relation to Head of Charge 6.

You have further submitted that Heads of Charge 2, 3, 4, 5, 7, 8 and 9 which relate to patients A to F all concern complaints about Dr Cosgrove where information was submitted to the GMC in the years 1997 to 2000. There is no evidence before the Committee that these complaints were orchestrated by CCHR. The Committee acknowledge that there were enquiries from CCHR as to the progress of Head 6 but not in relation to the other cases being considered at that time. In the light of not having found an abuse of process in relation to Head 6, the Committee consider that the GMC has not been influenced by CCHR in their decision in relation to Head 6. As a consequence the
Committee find that there has been no abuse of process on this submission in relation to Heads 2, 3, 4, 5, 7, 8 and 9.

The Committee next considered the second submission made in relation to a stay of these proceedings due to an abuse of process. The basis of this submission is that the internal procedures which were followed were an abuse of process and in addition there was legitimate expectation that the complaints would be taken through the performance procedures. You also submitted that the actions of the GMC towards Dr Cosgrove were in bad faith, a breach of promise and a breach of his legitimate expectation.

The Committee have carefully reviewed and considered all the evidence on this point. The GMC wrote to Dr Cosgrove in May 2001 in relation to some of the complaints made against him and it was indicated that these complaints would be put forward for consideration under the GMC’s performance procedures. The Committee have carefully considered your further submission that Dr Cosgrove had not had any correspondence from the GMC that other complaints were going to be investigated and as such had a legitimate expectation that those complaints had been closed and that no further action would be taken.

The Committee have limited evidence which suggests that further information was submitted to the GMC which triggered a review of the earlier decision to submit the complaints to the performance procedures. Whilst the new information which led to the review of the earlier cases did not lead to additional charges being formulated against Dr Cosgrove, a decision was taken that the matters in question were conduct matters rather than performance matters and this was communicated to Dr Cosgrove in the Rule 6 letter dated 1 October 2002. The Committee note that the Medical Act and the GMC Procedure Rules are silent on the legitimacy of such a change. They have determined that insufficient evidence has been adduced whereby the Committee could come to a decision that changing the way in which the complaints were to be pursued amounts to an abuse of process.

The Committee note that the GMC has not disclosed internal documentation concerning the initial screening process and after due consideration were of the view that this did not produce manifest unfairness to Dr Cosgrove. Therefore, the Committee do not find that there has been an abuse of process.

In relation to your submission with regard to Dr Cosgrove’s legitimate expectation that due to the passage of time complaints were closed or that no action was to be taken, the Committee have carefully considered the advice tendered by the Legal Assessor and concur with that advice. The Committee considered that whether or not Dr Cosgrove’s legitimate expectations had been breached was only relevant to whether the Administrative Court would have quashed any of the GMC’s procedures had they been challenged prior to this hearing. The test they applied was whether the conduct which is said to have breached Dr Cosgrove’s legitimate expectation amounted to abuse of the process as defined in the Legal Assessor’s advice. The Committee have considered the facts placed before them and whilst it is regrettable that Dr Cosgrove was not kept fully informed of progress with regard to the complaints made against him, this does not amount to an abuse of process. The Committee therefore reject your application that there has been an abuse of process in relation to charges 2, 3, 4, 5, 6, 7, 8 and 9. It follows that there is no abuse of process in relation to Heads of Charge 10 and 11.
The Committee next considered your submission that Head of Charge 2 should be stayed on the grounds that the parents of Patient A have not given consent for the medical records to be disclosed for the purposes of this hearing. It is your submission that without the contemporaneous notes relating to Patient A’s treatment and care Dr Cosgrove would not have a fair hearing. The Committee note that Counsel agree that the Committee could exercise their powers under rule 50 of the GMC’s Procedure Rules to have the medical records disclosed. In considering this matter the Committee balanced the public interests and Dr Cosgrove’s interest in having a fair resolution of the allegations against Patient A’s right to confidentiality. The Committee are mindful of their powers in relation to hearing evidence in private and consider that this would be the appropriate step to take in relation to Head of Charge 2. In so doing the public interest is served in resolving these matters and Patient A’s confidentiality is respected. The Committee therefore reject your application to stay this Head of Charge and wish to exercise their powers under rule 50 to have the medical records at the substantive hearing.

That concludes this phase of the enquiry and that is the end of business for today. The Committee Secretary will speak to you outside once the Panel has left but my understanding is that the dates which had been canvassed at some point last week if we were going to a substantive hearing are 9, 10 and 11 June and the five days in the subsequent week beginning 14 June. The hearing would be in Manchester. That is eight days. If there is any alteration to that, no doubt it will be dealt with by the secretariat. Thank you very much.

*The hearing was concluded.*
GENERAL MEDICAL COUNCIL

PROFESSIONAL CONDUCT COMMITTEE

On:
Wednesday, 9 June 2004

Held at:
St James’ Building
79 Oxford Street
Manchester M1 6FQ

Case of:

PATRICK VERNON FINN COSGROVE MB BS 1968 Lond
(Day Six)

Committee Members:
Professor Norman Mackay (Chairman)
Dr Alison Hamilton
Mr John Matharu
Dr Belinda Stanley
Mr Richard Briden (Legal Assessor)

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MR D MORRIS, of Counsel, instructed by Messrs RadcliffesLeBrasseur, appeared on behalf of Dr Cosgrove, who was present.

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

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

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THE CHAIRMAN: Good morning. This Committee has reconvened from a hearing which took place in January to consider the case of Dr Cosgrove. At the session in January there was before the Committee an application for abuse of process, or a stay of proceedings as a consequence of an abuse of process, but that application was subsequently refused and so the Committee will now proceed to consider the case of Dr Cosgrove.

Dr Cosgrove is not present, but is represented by Mr David Morris, Counsel, instructed by Radcliffe Le Brasseur solicitors, and Mr Richard Pearce, Counsel, instructed by Field Fisher Waterhouse solicitors, represents the General Medical Council.

In January we did read the Heads of Charge at the commencement of the hearing and normally at the resumption of an adjourned hearing we do not read the charges, but I think such is the time interval since then and to give Mr Morris the opportunity to respond to the Heads of Charge that I will ask the Committee Secretary to read out the Heads of Charge.

THE COMMITTEE SECRETARY: The Committee will inquire into the following charge against Patrick Vernon Finn Cosgrove, MB BS 1968 Lond; MRCS Eng LRCP Lond 1968 SR:

"That, being registered under the Medical Act,

1. At all material times, you were practising as a Consultant Child and Adolescent Psychiatrist working in private practice at the Bristol Priority Clinic;

2. a. On 3 May 1996, you saw Patient A, a child who had been diagnosed as suffering from Attention Deficit Hyperactivity Disorder (ADHD),

b. You prescribed drugs to Patient A as follows:

   i. between May 1996 and May 1999, you prescribed methylphenidate (Ritalin),

   ii. by July 1996, you had increased the prescribed dose of Ritalin to 62.5 mg per day,

   iii. in May 1998, you increased the daily dosage of Ritalin to 100 mg per day,

   iv. by May 1999, you had increased the dose of Ritalin to 130 mg per day,

   v. from July 1996, you prescribed an additional daily dosage of risperidone at 1 mg per day,

   vi. by November 1998, you had in addition prescribed clonidine as
a night time sedative,

c. Having so prescribed, your monitoring of Patient A was irresponsible in that

i. you did not see Patient A in person between May 1996 and May 1999,

ii. you did not make an adequate assessment of Patient A’s weight,

iii. you did not monitor Patient A’s growth,

iv. you did not warn Patient A’s mother that sudden withdrawal of clonidine could have a deleterious effect on Patient A’s blood pressure,

v. you did not advise Patient A’s General Practitioner (GP) to monitor Patient A as above;

‘3. a. On 1 December 1999, you saw Mr B as a private patient and diagnosed that he was suffering from ADHD,

b. On 3 December 1999, you wrote a letter about that consultation to Dr Humphreys, Mr B’s GP, which letter you copied to Dr K Al-Shabner and to Mr and Mrs B,

c. In that letter, you stated as follows:

i. that Mr B had seen a doctor who might have been Dr Al-Shabner,

ii. that the doctor whom Mr B had seen had been rude and unhelpful,

iii. that the doctor whom Mr B had seen had been scruffily dressed,

iv. that the doctor whom Mr B had seen knew nothing about ADHD,

v. that the doctor whom Mr B had seen was guilty of medical negligence,

vi. that the doctor whom Mr B had seen had demonstrated professional incompetence,

d. The comments that you made in the said letter were

i. unprofessional,
ii. unsustainable,

iii. likely to cause the reader to doubt Dr Al-Shabner’s knowledge and/or skills;

'4. a. On 27 May 1999, you saw Master C, a nine year old boy, as a private patient,

b. On 29 May 1999, you wrote a letter to Master C’s GP about the consultation, sending a copy of the letter to Dr Karin Moses, Consultant Child Psychiatrist responsible for the treatment of Master C under the NHS,

c. The said letter requested that Master C’s GP prescribe him risperidone and Ritalin,

d. The letter did not contain any advice for Master C’s GP about appropriate monitoring of Master C whilst he was taking those drugs,

e. Your failure to provide such advice to Master C’s GP was

i. irresponsible,

ii. not in the best interests of Master C;

'5. a. On 7 July 1999, you wrote a letter to Dr Karin Moses, which letter you copied to Master C’s parents and his GP,

b. In that letter, you stated

i. that Dr Moses was likely to deny some or all of what Master C’s parents had told you about her treatment of Master C,

ii. that Dr Moses had seen Master C only once whilst he was a day patient on the children’s psychiatric unit at St Cadoc’s Hospital, Caerleon, Newport, during which period Master C was getting worse and worse when he should have been getting better and better,

iii. that Dr Moses owed Master C’s parents an explanation as to why she had not prescribed Ritalin during the time that Master C was a patient at the children’s psychiatric unit,

iv. that when Dr Moses first saw Master C he was aged 5 years old, and that she made no diagnosis and that she had done nothing that resulted in alleviating Master C’s malfunctioning,

v. that nothing that Dr Moses had done when she saw Master
C aged 5, 6 and 7 years had prevented his behaviour causing him to be asked to leave two schools and to be admitted to St Cadoc’s Hospital,

c. The comments that you made in the said letter were

i. unprofessional,

ii. unsustainable,

iii. likely to cause the reader to doubt Dr Moses’ knowledge and skills;

‘6. a. In or about May 1996 you saw Master D, a ten year old boy, as a private patient,

b. You diagnosed Master D as suffering from ADHD,

c. You prescribed Ritalin for Master D,

d. Your examination of Master D on that occasion was inadequate in that

i. you did not weigh him,

ii. you did not take his blood pressure,

e. You subsequently spoke to Master D’s mother by telephone, following which you prescribed risperidone,

f. You failed to make proper arrangements for monitoring the effects of the treatment which you provided for Master D;

‘7. a. In or around August 2000, Oxfordshire Mental Healthcare NHS Trust carried out an investigation into a number of features of the treatment of a patient of the Trust, Patient E,

b. On 29 September 2000, Miss Wendy Samways, Complaints Manager at the Oxfordshire Mental Healthcare NHS Trust, wrote to you requesting copies of your medical records concerning Patient E and enclosing signed authorisation for the release of the records,

c. By a letter dated 3 October 2000, you replied to Miss Samways that you would not supply the medical records,

d. Your failure to supply the notes as requested was

i. inappropriate,

ii. unprofessional;
‘8. a. In the letter referred to in paragraph 8c above, you also stated as follows:

i. that Patient E had been given inadequate care by an employee of the Oxfordshire Mental Healthcare NHS Trust,

ii. that the investigation being carried out might end in a whitewash of such inadequate care,

iii. that you believed the investigation to be a cover up of grossly inadequate care received by Patient E from the Trust,

iv. that the investigation was programmed to ensure that the Trust was not criticised at all or only criticised in a minor way,

b. The comments set out in the letter were

i. unprofessional,

ii. unsustainable,

iii. likely to cause the reader to doubt the knowledge or skills of the employees of the Oxfordshire Mental Healthcare NHS Trust who treated Patient E;

‘9. a. By a letter dated 17 November 2000, concerning a patient Mr F, which you sent to his GP, and copies of which you sent to Dr Helen Chubb, Consultant Psychiatrist at the Cardiff and Vale NHS Trust and Dr Miranda Thomas, SHO in psychiatry at the same Trust, you stated that you had diagnosed Mr F as suffering ADHD and that you had prescribed him Ritalin,

b. That letter did not contain any advice to the prescribing GP about the monitoring of Mr F,

c. In the letter, you stated as follows:

i. that Mr F had not felt that Dr Thomas had listened to him when he talked about his personal understanding of ADHD,

ii. that Dr Thomas had stated that “concentration problem is for messy kids”,

iii. that the comment alleged to be made by Dr Thomas was an ignorant comment,

iv. that both Dr Thomas and Dr Chubb were arguably guilty of medical negligence in knowing less about ADHD in adults than Mr F,
v. that Dr Thomas had made an assertion of “therapeutic nihilism” in saying “the consultant thinks that you have got a personality disorder which is not treatable”,

vi. that if Mr F responded to treatment for adult-type ADHD, it would indicate that Dr Thomas and Dr Chubb were negligent in not listening to Mr F and in not knowing about ADHD as a real condition in adults, leaving room for formal complaint to the Fitness to Practice Directorate of the General Medical Council,

d. The comments that you made in the said letter were

i. unprofessional,

ii. unsustainable,

iii. likely to cause the reader to doubt the knowledge or skills of Dr Chubb and Dr Thomas;

‘10. a. In or around January 2003, you saw a 4 year old child, Patient G, as a private patient,

b. Thereafter, you prescribed Ritalin and risperidone to Patient G,

c. By May 2003, you were prescribing

i. Ritalin at 25 mg per day,

ii. risperidone at 0.625 mg per day,

d. Having so prescribed, your monitoring of Patient G was irresponsible in that

i. you did not make an adequate assessment of Patient G’s weight,

ii. you did not monitor Patient G’s growth,

iii. you did not adequately monitor any possible side effects;

‘11. a. On or around 16 July 2003, you saw Patient H as a private patient,

b. On 19 July 2003, you wrote to Patient H’s GP, which letter you copied to Patient H’s parents and to Dr Dover, a Consultant Psychiatrist who had treated Patient H,

c. In that letter you stated amongst other things
i. that, if Dr Dover did not believe in ADHD, he might have difficulty in being revalidated by the General Medical Council,

ii. that Dr Dover should have studied Patient H’s school reports,

iii. that Dr Dover had behaved in a professionally unacceptable manner by not arranging a second opinion when asked to do so,

b. The comments that you made in the said letter were

i. unprofessional,

ii. unsustainable,

iii. likely to cause the reader to doubt the knowledge or skills of Dr Dover;'

“And that in relation to the facts alleged you have been guilty of serious professional misconduct.”

THE CHAIRMAN: Thank you very much.

Mr Morris?

MR MORRIS: Sir, may I first of all confirm the obvious that Dr Cosgrove is at present not attending the inquiry, but that in his current absence I am instructed to proceed to represent his interests.

Turning to the Notice of Inquiry, I can tell the Committee that the following matters are admitted: Head of Charge 1; Head of Charge 2(a); Head of Charge 3(a), Head of Charge 3(b), under Head of Charge 3(c) (i), (iv), (v) and (vi) and Head of Charge 3(d), (iii).

Under Head of Charge 4: (a), (b), (c) and (d).

Under Head of Charge 5: (a), under Paragraph (b) (i), (iii), (iv) and (v) and under Head of Charge 5 (c), (iii).

Under Head of Charge 6: (a), (b), (c) and (e).

Under Head of Charge 7: (a), (b) and (c).

Under Head of Charge 8: (i), (ii), (iii), (iv) - I am sorry, 8(a) I beg your pardon. 8(a) (i), (ii), (iii) and (iv) - and Head of Charge 8(b) (iii).

Under Head of Charge 9: (a), (b), under Paragraph (c) (i), (iii), (iv), (v) and (vi) and under (d), (iii).
Under Head of Charge 10: (a), (b) and (c) in its entirety. (c) in its entirety.

Under Head of Charge 11:

Head of charge 11(a), (b) and (c) in its entirety. Head of charge 11 (b) (iii).

THE CHAIRMAN: Do you mean 11 (d) (iii)?

MR MORRIS: I mean 11 (d) (iii). I do apologise.

Sir, something has just been pointed out to me. I think for safety’s sake can I go back to Head of Charge 10c, which is, “By May 2003 you were prescribing one Ritalin and two risperidone.” That paragraph c should not be admitted.

THE CHAIRMAN: Perhaps I could just go over these again, the charges which have been admitted and consequently found proved are 1; 2;

3a, 3b, 3c i, iv, v and vi, 3e ii;

4a, b, c, and d;

5a, 5b i, iii, iv, v, 5c iii;

6a, b, c and e;

7a, b, c;

8a i, ii, iii and iv, 8b iii;

9a, b, 9c i, iii, iv, v and vi, 9d iii;

10a and b;

11a, b, c in its entirety and 11d iii.

MR MORRIS: I believe, sir, you said that Head of Charge 2 was admitted without qualification.

THE CHAIRMAN: 2a.

MR MORRIS: 2a is admitted but the rest is not admitted.

THE CHAIRMAN: 2a and the rest of 2 is not admitted. So, I think we have now got agreement on what has been admitted and proved and what has not. Mr Pearce.

MR PEARCE: I am obliged, sir. Dr Patrick Vernon Finn Cosgrove qualified with MBBS from London University in 1968. He holds the qualifications of membership of the Royal College of Surgeons in England, he is a Licentiate of the Royal College of Physicians of London. He is a specialist in child and adolescent psychiatry.
At the time relevant to the matters with which the Committee is concerned, he practised from the Bristol Priority Clinic, a private clinic. That was in practice as a consultant child and adolescent psychiatrist.

These Heads of Charge all arise out of cases in which Dr Cosgrove has been involved in treating patients for attention deficit hyperactivity disorder - ADHD.

ADHD is a common and well-recognised psychiatric disorder for children and adolescents. Recent evidence suggests that symptoms might continue into adulthood, thought this is a field where far less is known about the condition. Diagnostically the condition is characterised, as the name suggests, by a combination of a deficit in attention and an element of excessive activity, hyperactivity. In addition the syndrome is typically associated with symptoms of impulsiveness. It tends to be associated with significant school-based problems, particularly poor achievement and behavioural difficulties.

Treatment of ADHD has been by a variety of techniques, including most significantly, for the purposes of the matters you are concerned with, behavioural management and through medication. Of the medication that has been used in this country at least, Ritalin, which is the proprietary name for methylphenidate hydrochloride is the most commonly used medication. Ritalin essentially is a stimulant which has been proved effective in the treatment of ADHD in many cases.

Dr Cosgrove has worked extensively in this area. He has written on, amongst other things, the use of risperidone, an anti-psychotic drug, to augment the use of stimulants such as Ritalin.

Sir, I anticipate that this Committee will hear evidence certainly from Professor Taylor, whom I intend to call and possibly from other sources, that will indicate to the Committee that there is a range of view about the use of drugs in dealing with both children and adults who present with ADHD.

It is, I hope, fair to say that Dr Cosgrove’s views lie towards one end of that spectrum, in the sense that he is a psychiatrist who has been more ready then many to prescribe drugs.

Many of the Heads of Charge here relate to the manner in which he has spoken of and to other psychiatrists who do not share his views and who lie, perhaps, at a different point in the range of opinions.

The charges against Dr Cosgrove, then, relate to the circumstances surrounding prescriptions to a number of individual patients and to correspondence arising out of those prescriptions. You will have noted, sir, from the charges that consecutive letters of the alphabet have been used to preserve anonymity and you will recall that on the last occasion concern was expressed about anonymity for patients, a course which we will seek to preserve by using those consecutive letters.

If I may, then, take you through the charges and the individual patients with whom we are concerned and give you something of the background to each of those patients.
Charge 2 relates to Patient A. This was a child who was referred to Dr Charles Holme, a consultant community paediatrician based at that time at Salisbury District Hospital. The referral was made by a doctor who felt that Patient A was showing symptoms of ADHD.

Patient A was prescribed methylphenidate but subsequently was referred by the general practitioner to Dr Cosgrove.

Dr Cosgrove saw Patient A and his mother on 3 May of 1996. Thereafter he prescribed a rapidly increasing dose of Ritalin for Patient A. This caused concern to Dr Holme, the paediatrician to whom I have referred and to a local psychiatrist. They reviewed the case and agreed that the management of the Ritalin prescription should be left to Dr Cosgrove alone.

Dr Cosgrove then reviewed the progress of Patient A with his mother and progressively raised the dose of Ritalin to 62.5 mg daily adding the risperidone and latterly clonidine, a night-time sedative.

By May 1999 it appears that the dose of Ritalin had increased to 130 mg a day with risperidone and clonidine being taken on a daily basis. This dosage increase had taken place without Dr Cosgrove reviewing Patient A in person and without, we say, proper monitoring having taken place.

130 mg of Ritalin per day is a very high dosage indeed. That is not to say that it was necessarily inappropriate and you will have noted from the charges that in no case do we criticise the dosage per se. If such a high dosage of Ritalin is to be prescribed, then the importance of the kind of monitoring to which I will return in due course is all the greater. We say there was a failure properly to monitor here.

The level of dosage was such as to cause concern to Dr Holme, who communicated that concern to Dr Cosgrove. It seems that Dr Cosgrove then reviewed Patient A and recommended a reduction in dosage. Subsequently Patient A’s care was taken over by a different psychiatrist.

I turn if I may, now, sir, to Charge 3, Patient B. It would be appropriate at this point, if I may, to produce to the Committee a bundle of documents that I will refer to in respect of this charge and some of the other charges. (Produced)

THE CHAIRMAN: We will refer to this as C8, the reason being that we got up to C7 on the previous occasion and we do not want to confuse documents.

MR MORRIS: It is immediately convenient to flag up in terms of this bundle, as described on the front of it, it has been tabbed in such a say that the tab numbers cross-relate to the charge numbers, which is why numbers 1, 2 and 8 are missing because there are no documents relevant to those charges.

If I might just give a little of the background in relation to Patient B before we turn to the relevant documentation. Patient B was an adult patient of Dr Sean Humphreys, a general practitioner in Aberystwyth. Patient B was referred to Dr Al-Shabner, a psychiatrist employed by the Pembrokeshire and Derwen NHS Trust. Dr Al-Shabner saw Patient B in
late 1999.

Patient B was also referred to Dr Cosgrove and Dr Cosgrove wrote a letter to the patient’s general practitioner, Dr Humphreys, on 3 December 1999. In that letter Dr Cosgrove sets out evidence of Patient B’s inattentiveness, poor motivation and his impulsive behaviour.

Dr Cosgrove goes on to indicate that he considers that Patient B has attention deficit hyperactivity disorder - ADHD. The letter the goes on to deal with the recent appointment that Patient B has had with Dr Al-Shabner.

If I may turn to tab 3 - at the risk of confusing, I should say that when these documents were anonymised, they were done by simply leaving initials of the first name and surname, so one sees other letters but it this fact relates to Patient B.

I will not take you, if I may, to the first part of the letter. May I take you to page 2. A little over half way down - and if you will excuse me for reading through this and other parts of relevant correspondence so that the Committee is aware of what matters we are concerned with.

Dr Cosgrove is here dealing with Patient B’s recent appointment and says as follows:

“I was perplexed as to which local adult psychiatrist Patient B actually saw. Your referral letter is written to Dr Thorpe-Belton but Patient B said that he saw a Dr Guyse although the person he met never introduced himself. However, the letter you received from the Gorwelion Day Hospital was from Dr K Al-Shabner, who describes himself as an Associate Psychiatrist.

There is some importance in this, since whoever Patient B actually saw, he found him to be rude and quite unhelpful. Patient B describes his as being a scruffily dressed man in his fifties or possibly his forties. The appointment got off to a bad start when the doctor sped on ahead so that Patient B found himself at the top of some stairs with no-one in sight and not having a clue as to where to go. This doctor then appeared to rebuke Patient B by saying that he had been waiting for him.

During the interview, Dr Al Shabnder or Dr Thorpe-Belton or Dr Guyse then asked D what the date was, which floor of the building he was on, and to subtract 7 from 100 and then 7 from 93. By this time, D was thoroughly irritated by the offensive manner in which he was experiencing he was being treated that he told this person that he was rude.

Anyhow, this specialist declares (I was told) that “there’s nothing I can do for you”. Indeed, this fits with Dr Al Shabner telling you that he had left the diagnosis open to Patient D. I find this a truly amazing statement. Sure it is the doctor specialist who makes the diagnosis so that it is not something to be left up to the patient. This doctor says that he did inform
Patient D that he may or may not be have Deficit Syndrome, “as he calls it” and “I somehow at least let him start thinking of why it is that important to him at this moment in time.

It is clear from Dr AlShabnder’s total misuse of the word “Deficit Syndrome” that he knows nothing about ADHD. ADHD is well described in both international classifications of mental and behavioural disorders where is (ICD-10 and DSM 4) where it is clearly stated that ADHD can continue into adulthood.

In view of his appalling failure of knowledge about ADHD, in view of Dr AlShabnder’s failure to elicit the simply dreadful level of Patient D’s motivation (“he seems to be well motivated”), in view of his rudeness as reported by Patient D, in view of his statement about “there’s nothing I can do for you” (when ADHD responds so well to dopaminergics like Ritalin or Dexamphetamine), I must formally register my strong disapproval of the medical negligence of this doctor.

Of course, Dr AlShabdner is a non-consultant member of the tam, then this professional incompetence must surely reflect on the teaching of the consultant in charge, whom I presume is Dr Thorpe-Belton, to whom you originally referred your patient.

Then Dr Cosgrove goes on to making out a prescription.

We contend that comments of this nature, and you will find that there is a thread of similar comment in a number of documents, are unprofessional, unsustainable and likely to cause the reader to doubt the knowledge and skills of the doctor, here we say Dr AlShabdner.

May I turn, sir, to Patient C. The relevant charges are numbers four and five. Patient C started to the attend the Pollard Well Children's Unit at St Cadoc’s Hospital in Newport in November 1998. He had daily contact with specialist teaching and nursery staff, he was reviewed weekly at multi-disciplinary staff meetings, at which a consultant in child adolescence, Dr Karen Moses, was present. Subsequently Patient C was seen by Dr Cosgrove. Dr Cosgrove then wrote to C’s General Practitioner by letter dated 29 May 1999. This letter appears, sir, at division four in the bundle. In that letter, to summarise for a moment, Dr Cosgrove indicates that C has the Attention Deficit Hyperactivity Disorder, he indicated he started the patient on a low dose of Risperidone to be followed two days later by a dose of Ritalin, the dosage is then to be increased.

This letter to the General Practitioner indicates that Dr Cosgrove has written private prescriptions but invites the General Practitioner to copy those sent on to an NHS script. On subsequent occasions it is said that Dr Cosgrove was sending to the parents a specimen script to bring to the GP so that the prescriptions could be altered. The prescription of these drugs without proper monitoring is not appropriate. The letter contains no advice to the General Practitioner about monitoring and the submission that we make: this is irresponsible and not in the best interests of the patient.
So it is also significant to note the contents of the letter and what Dr Cosgrove has to say about Dr Moses. If you look at page two you will note that, first of all, at the very bottom this is a letter copied to Dr Moses, in fact, page one is clearly a letter to the General Practitioner, but copied to Dr Moses. I have not referred to, but might in passing mention that in division three relating to patient B on page three of that letter, it was copied by Dr Cosgrove to both Dr AlShabdner and to patient B’s parents.

Dealing with Patient C and Dr Moses a third of the way down page two of division four:

“Mrs C”,

I understand to be Patient C’s mother,

“told me that Patient C was seen by Dr Moses, Consultant Child Psychiatrist, when he was five years old but she was given no diagnosis. At this time she was being called into school every week and she considers that her son was hyperactive at that stage. Dr Moses saw Patient C again when he was six, had half an hour talk with his mother and told her that she should see Patient C again in one year’s time. His mother said that Dr Moses has seen Patient C three times in four years. In view of the serious state that Patient C is now in, I am surprised that more has not been done for this poor child by the local specialist. Fortunately Mrs C has the financial wherewithal to bring her son to see me but one dreads to imagine how other mothers, who cannot pay to go privately, are faring.”

Dr Moses, having received what a copy of what you may think is clearly a letter critical of her or her team, responds in a letter that appears in division five, page one:

“Dear Dr Cosgrove,

Thank you for sending me a copy of your letter on this boy. At the time you saw him he was a day patient on our Children’s Psychiatric Unit. It would seem that you did not elicit this piece of information.

I am most unhappy about your intervention with this boy and with your false assumption that not more has been done for this poor child by the local specialist.”

So Dr Cosgrove replied to that by letter dated 7 July 1999 that appears at pages two to four of division five in the bundle. If you will forgive me, I will read this in its entirety, sir, because, in our submission, this letter amounts to a an unwarranted diatribe against Dr Moses, which you will note from page four of division five was copied to parents of Patient C and to the General Practitioner:

“Dear Dr Moses,

Thank for your letter of 1 July in which you say that:
1) I did not elicit the fact that Patient C was a day patient on your Children's Psychiatric Unit.

2) I am most unhappy about your intervention with this boy,

3) I am most unhappy with the false assumption that not more has been done for this poor child by the local specialist.

In relation to 1), I was told by the General Practitioner, Dr Rackham, that Patient C “has been under the care of Dr Karen Moses at St Cadoc’s Hospital.” Put like that it could mean that he has been under in your care but is no longer. But anyhow, even if Patient C was still under your care, the GP is entitled to ask for a second opinion and hence he states at the end of his referral letter to me? “I would be grateful for your opinion.”

When I met Mr and Mrs C I was told that Patient C had been attending St Cadoc’s Hospital five days per week since November 1998. I was also told that in that time of some six months you have seen Patient C only ONCE and that, furthermore, you had told his parents that you were going to prescribe a sleeping tablet at night for C. This never happened! You neither prescribed this medication you had promised nor did you explain to his parents why you had changed your mind and were no longer going to prescribe it.

I appreciate that you are likely to deny some of or all of this, which is what the parents have told me. Whether or not the parents have reported to me everything totally accurately is of less relevance than what they consider to have happened (or not happened) as the case may be. Anyhow, the number of times you actually did see him, as he was under your consultant care, would be recorded in his notes and would be beyond dispute.

So you see, I did elicit the piece of information that C was a day patient on your Children's Psychiatric Unit at the time I saw him. He had been there for six months; you had seen him only once and he was getting worse and worse when he should have been getting better and better.

…2) you are unhappy about my intervention with the this boy. Why are you unhappy? After all you told the parents that you agreed with C being prescribed Ritalin. If you agreed with the prescription of Ritalin why did you not prescribed it for him during the six months he was in your Children's Psychiatric Unit? I am sure you owe C’s parents an explanation on this particular point!

Why are you unhappy? I feel sure that your unhappiness will turn to sheer joy and happiness when I tell you that within ten days C was very much better. He has ceased being aggressive and abusive and his maternal grandmother has had him visit her three times over one weekend since starting the medication compared with the no visits during the last eight months – six of which he was in your Children’s Psychiatric Unit.
attending for five days per week! So why should you be unhappy about my intervention?

As a result of my intervention, Durands School have now changed their mind and are going to have him back - following a visit from a member of their staff. His mother says that her son is “a lot better” and that there has been “a great improvement”. So why be unhappy about my intervention? Perhaps you will be good enough to write to me to tell me why you are most unhappy about my intervention when the child concerned is transformed. I cannot believe that you as a caring doctor would do anything else but rejoice with me and with C and with both his parents that C is back to good health.

As regards 3) you are most unhappy with my false assumption that “not more has been done for this poor child by the local specialist.” You first saw C when he was five years old when he was not eating, was thin, was having frequent tempers, when the parents were being called into school on a weekly basis. You made no diagnosis and did nothing that actually resulted in and alleviation of this child’s malfunctioning. You saw him again when he was six years old and had one half hour’s talk with C’s mother. There was a similar meeting when he was seven years of age. So that you have seen C and his mother three times in four years. What did you actually achieve by these three meetings. I will would appreciate it if you would write to me and tell me what you achieved by these three appointments.

In 1998 he was not allowed to return to Caldicot St Marys school because of his behaviour there during the previous academic year. In September 1998 he was expelled from school after one month there because of his violence to other children and because he complete refused to any of the work that the teachers set. In November 1998, he was admitted under you. Please tell me, please, what benefit your three interventions/sessions/appointments were when he was 5 and 6 and 7 years of age. Nothing you said or did on those occasions prevented his behaviour causing him to be asked to leave from two schools last year and from being admitted to St Cadoc’s.

If you can tell me what you achieved for C from 5 years to now, then I will withdraw my comment that makes you most unhappy and apologise to you. I look forward to hearing your justification of what you did when you saw the boy and his mother three times in four years.

I note that you letter is headed in bold, black capital letter Restricted and Confidential Information. You are a public servant, being paid by public monies and employed in a public service. You are, therefore, publicly accountable I will not have correspondence going between you and me that disallows the parent from knowing what is being said about them and about their son, C. I have ignored this restriction by quoting
verbatim from your letter and by sending a copy of this letter to you, Mr and Mrs C and to Dr Rackham. I look forward to hearing from you”.

I described it as a diatribe, sir, and that in our submission it is. Robust criticism of a fellow professional is one matter. This goes in our submission far beyond that and far into, we say, the territory of criticisms which are likely to undermine confidence in fellow medical practitioners and which are likely and liable to cause harm to medical treatment and I will return to that point.

Sir, Patient D is referred to in Charge 6 and Charge 6, just so that you are aware, is the charge or at least the patient and his mother to whom a great deal of reference was made last time and from whose mother we contend at least you heard on the last occasion.

Patient D was born on 12 February 1986 and so that makes him now eight years of age. As a result of poor behaviour at school, his mother became -- I am sorry, that is a bad miscalculation. That makes him 18 years of age, not eight, does it not?

As a result of poor behaviour at school, his mother became considerably concerned. She happened upon a television programme where the issue of ADHD was being discussed and, realising that the characteristics described were similar to those of her son, she investigated further and through a Family Support Group she was put in touch with Dr Cosgrove.

In May 1996 she took her son to see him and the consultation took she estimates 15 to 20 minutes, during which time Dr Cosgrove asked various questions about her son's behaviour and she completed a questionnaire about her son. However we contend that Dr Cosgrove did not speak directly to Patient D, notwithstanding the fact that he was then ten, nor did he carry out a physical examination. Dr Cosgrove diagnosed ADHD and told the patient's mother that he could assist by prescribing Ritalin on a private prescription, which he did.

The failure of Dr Cosgrove to weigh Patient D or to take his blood pressure was, we say, inappropriate and inadequate.

D's mother paid Dr Cosgrove £160 in cash, and Dr Cosgrove indicated that he would check on D's progress by telephoning in a fortnight and that would cost £25. Dr Cosgrove duly telephoned two weeks later and D's mother explained that she was still having problems with her son's behaviour. Dr Cosgrove indicated that he would increase the dose of Ritalin.

Two weeks later, again Patient D's mother spoke to Dr Cosgrove by telephone. She indicated that she was concerned about her son not eating or sleeping and him losing weight. She explained this to Dr Cosgrove, who said that he would prescribe another drug which would help her son's sleep and would, as he put it, counterbalance the Ritalin. This drug was risperidone. D's mother also asked whether she should seek help from Psychiatric Services, to which Dr Cosgrove replied that this was not necessary and that he could prescribe all that was necessary to deal with D's condition. Dr Cosgrove then sent a private prescription for risperidone and D's mother obtained the drug.
D remained on Ritalin and risperidone for a number of years. However, after the first visit Dr Cosgrove did not see him. It was, we submit, inappropriate for this treatment to continue without monitoring taking place by Dr Cosgrove.

Sir, Charges 7 and 8 relate to a Patient E and an investigation of features of the treatment of his care at the Oxfordshire or via the Oxfordshire Mental Healthcare NHS Trust.

Patient E, as I say, was treated in that Trust and he was also a patient of Dr Cosgrove. Following a complaint from his parents about the treatment at the Trust, the Trust launched a review. Miss Wendy Samways, a Complaints and Patient Advice Liaison Service Manager at the Trust, wrote to Dr Cosgrove requesting a copy of his notes. In Division 8 of the bundle -- I am sorry, it is Division 7. I will get the numbering right, I apologise. At Page 1 of Division 7 you will see a letter from Miss Samways to Dr Cosgrove requesting copies of any medical records that he might hold.

Sir, the response of Dr Cosgrove to that letter appears in a letter at Pages 2 and 3 of Division 7. Again that is copied to this patient's parents, as you will see at the bottom of Page 3, and again if you will excuse me I will read it out at length now:

"Dear Miss Samways,

Thank you for your letter of 29 September and your request for copies of any medical records that I hold regarding Patient E. I note that you have enclosed signed authorisation and request that I send you copies of any medical records.

I am unwilling to accede to your request in the matter. I do not believe that the independent expert will be truly independent nor sufficiently knowledgeable concerning the treatment that I have given to E subsequent to my taking over his care from Dr McDonald. I am concerned that I am being drawn into a process which, in the end, will whitewash the circumstances of E's inadequate care given by an employee of your Trust. It seems to me inevitable that the Trust will come to a final decision which first and foremost will ensure that the Trust cannot be sued by Mr and Mrs E in regard to the care of their son.

I assert that the expert you have called upon will not be sufficiently independent to do justice in this case for E and his parents. The independent expert will never, ever say anything that would cause Dr McDonald any distress or difficulty with employment for the simple reason that this so-called independent witness will always face the unpleasant prospect of coming face to face with Dr McDonald in the future at conferences and meetings. The expert witness will have this in the forefront of his/her mind in coming to a conclusion on this matter.

I assert that the expert will also not be knowledgeable or
experienced enough with the use of risperidone which is not only the medication that has dramatically changed E's treatment but is precisely the medication that Mrs E was calling upon Dr McDonald again and again to prescribe, but which he persistently refused to do so. His constant refusal to do this was partly because of your Trust's policy not to prescribe this medication to children.

I am probably the most experienced specialist in the UK in the use of risperidone with children, having treated more than 500 young patients with it since 1993. You will not find an expert who will be able to do justice to E's case.

I am not prepared to become involved with what I believe will be a cover-up of the grossly inadequate care that this child, who is now my patient, has received in your Trust. You have set up a semi-secret system of investigation which will be programmed to ensure that the Trust comes out of it with a clean bill of health or with a few minor cosmetic points. Your independent expert will come under very considerable pressure to be kind and generous to a fellow medic and not to be troublesome to the Trust who has appointed him in the first place and probably paying him considerable expenses and fees for his trouble.

The only fair and just way to deal with Mr and Mrs E's complaints against your Trust and against Dr McDonald is to formally complain to the Fitness to Practise Directorate of the GMC. Here a medical screener, who will be unknown completely to your Trust, will decide if the complaint should go forward to the next stage which is Preliminary Proceedings Committee. This Committee consists of laypeople who will represent Mr and Mrs E's interests for justice better than any 'independent' medical expert that your Trust appoints. Furthermore, the medical members of the committee, not being psychiatrists and not having to meet Dr McDonald at any conferences, will be able to give a fair and impartial decision on that matter as to whether it should go forward to the next stage of investigation.

And finally, with the GMC involved, I will be able to put my views in on behalf of Mr and Mrs E and E. I find it incomprehensible that you should ask the specialist, who has transformed E in a way that your Trust was quite incapable of doing, to just simply send you copies of the medical notes. You should be asking me for my expert opinions on the matter and not just for the notes. However, please be assured that any requests from now on for my opinion from yourselves will not be forthcoming. For E and his parent's sake, the GMC is by far the best way to pursue their complaints".
Sir, a number of points arise from that letter in our submission. First of all, Dr Cosgrove was not attempting in any way to assist with the review procedure. Secondly he was criticising that procedure, and more particularly one named doctor and in a more general sense other medics at the Trust, in a manner which -- and you will have noted this admission under this charge, an admission which we say is quite an appropriate and inevitable admission, "... in a manner which is likely to cause the reader to doubt the knowledge and skills of employees of the Oxfordshire Mental Healthcare NHS Trust who treated Patient E". That is 8(b) (iii), sir, an admission which is similarly made under some of the other charges.

I have indicated already that there is a proper role for robust criticism but, sir, this kind of criticism shows first of all an arrogance on the part of Dr Cosgrove that he is the only person properly able to understand the patients' needs and properly able to treat them, whereas in fact we say that on any proper reading of the situation there is a range of opinion and that the criticism that he makes of others whilst no doubt genuinely and firmly held are not criticisms that can properly be made so as to put the conduct of others outside of the reasonable conduct of medical practitioners, but also that it is likely to interfere with the relationship between this Trust, Patient E, Patient E's parents and others to whom they speak. It is not, in our submission, good medical practice. It is not conducive to good and proper medical treatment.

Charge 9 relates to Patient F. Patient F is an adult patient, again, registered with the practice of a Dr Dolby. Dr Cosgrove saw Patient F in the Year 2000. At that time, Dr Helen Chubb was a Consultant Psychiatrist at the Cardiff and Vale NHS Trust and Dr Miranda Thomas was her SHO. Dr Thomas saw Patient F, during this period, and later Dr Cosgrove wrote a letter to F's General Practitioner, Dr Dolby, a copy of which appears at Division 9.

Again, if you will excuse me so doing, I will read at some length from the letter. Not from the first half of the letter, but picking up halfway down the second page. I think the typed numbers that appear in some of the divisions of the bundle do not appear on this particular document, but it is numbered I think handwritten number 232 in the bottom right-hand corner. It is the passage beginning, "He has been seen twice by Dr Melinda Thomas, who works for Dr Helen Chubb, Consultant Psychiatrist":

"Between them, these two psychiatrists came to the conclusion that Patient F has a Personality Disorder, and told him that there was no medication for it. He was told that referral would be made to a local psychiatrist who specialises in personality disorder. Patient F did not feel that Dr Thomas listened to him when he talked about his personal understanding of ADHD. She said that 'a concentration problem is for messy kids', which is such an ignorant comment to make in this new century. He told me that he felt so bad after attending this psychiatric outpatients. It is ironic and, arguably, even medically negligent that F knows more about ADHD in adults than both these two psychiatrists
Dr Thomas came back from telling Dr Chubb about F (for the latter has never seen him) with a sentence of therapeutic nihilism to say, 'The consultant thinks that you have got a Personality Disorder, which is not treatable'.

If F responds to treatment for adult-type ADHD, it will show that he has got a treatable disorder. Since personality disorder is untreatable, according to Drs Thomas and Chubb, it will that F does not have a personality disorder and that these two psychiatrists were wrong. It will also mean that F was right in his tentative diagnosis of ADHD in himself, and that they were negligent in not listening to him and in not knowing about ADHD as a real condition in adults. All this leaves room for a formal complaint to the Fitness to Practise Directorate of the GMC, and Dr Cosgrove then goes on to deal with a specimen prescription.

Again, these comments are in our submission highly critical and disparaging comments made in this case to the GP and copied to the psychiatrists but not, it appears in this case, copied to the patient or any relative of the patient himself. Again the comments show an arrogance that Dr Cosgrove's understanding of ADHD is the only proper understanding, and that others attempting to deal with patients in this field do not properly understand and do not properly have a knowledge base of the condition. Again, we say this is unsustainable and unprofessional.

Charge 10 now, sir, and I hasten to add I am coming to a conclusion fairly shortly now of this opening. Charge 10 relates to Patient G, born on 14 March of 1998 and so now six years old, who was seen by Dr Cosgrove in about February 2003 when he was prescribed Ritalin and then risperidone. Details of this attendance can be seen from a letter from Dr Cosgrove to the patient’s General Practitioner dated 25 February 2003, a copy of which appears at Pages 3 to 5 of Division 10. In this case I do not need to read from the letter, sir, but if we need to refer to any relevant parts of it in due course we will do.

Subsequently, though, this patient was seen by Dr Judge, a Consultant Child and Adolescent Psychiatrist. She discovered that Dr Cosgrove had seen G only once, had not adequately assessed his weight and had not subsequently monitored growth or any side effects of the medication.

It might perhaps conveniently be noted from the letter of 25 February 2003 that there is no reference to any system of monitoring save that on Page 4, just to flag-up this, about perhaps a fifth of the way down the page in the first full paragraph, there is reference to a series of telephone appointments with his parents in order to monitor his progress and to find the optimum dosage and frequency through the day. Such monitoring, in our submission, is not sufficient when dealing with medication of this nature.

Charge 11 relates to Patient H, sir, who was seen by Dr Cosgrove in July 2003. This was a patient who had previously been treated by a Consultant in Child and Adolescent Psychiatry.
Psychiatry, Dr Stephen Dover, and in Division 11, Pages 1 and 2, we see a letter from Dr Cosgrove to Dr Patel, Patient H's General Practitioner, and the form of the letter is we say all too familiar.

It deals first of all with ADHD, the diagnosis and the nature of the condition and the prescription, and then four lines up from the bottom of Page 1 of Division 11 continues as follows:

"I understand that H was seen by Dr Dover, Consultant Child Psychiatrist, about one year ago for one appointment. I was told by Mr and Mrs H that Dr Dover told them that he did not believe in ADHD, and that 'it was too Americanised'. I was informed that Dr Dover told H's parents to go away and to sort out their own lives. I was also told that Dr Dover did not read H's school reports nor did he ask to see them.

According to H's parents, his headteacher was concerned at what Dr Dover had told Mr and Mrs H to do, namely to 'go away and to sort out your own lives'.

And finally, I was informed that Dr Dover refused your own request to him for a second opinion.

I would like to say that, firstly, ADHD most definitely does exist and is clearly described and written about in the ICD10, which is not 'Americanised'.

Secondly, if Dr Dover really does not believe in ADHD, then he may have difficulty in getting revalidated by the GMC when his turn comes around.

Thirdly, Dr Dover should have studied H's school reports before blaming the parents' relationship for H's behaviour at school and at home.

Fourthly, it seems professionally unacceptable to me not to provide a second opinion when it is requested, especially when you yourself, as the child's GP, took the trouble to ask for it",

and then finally there is a reference again to specimen prescriptions.

Sir, I have said before and I repeat that the comments made by Dr Cosgrove in this letter and in other similar letters undoubtedly represent genuinely held opinions on his behalf. He is at times in the course of correspondence clearly referring to what he has been told about the conduct of other doctors, but you may think that in this letter and in other letters he readily adopts his understanding from typically parents of patients from what other doctors have said and then gives that validity by making criticism of the other doctors on the basis of it. You may think, for example in the case of Dr Dover, that he appears to have far too little information available to him to publicly make comments of this nature.
Sir, you will I have no doubt be aware that "Good Medical Practice" has something to say about matters of this nature and it is perhaps helpful if I just flag that up now so that we have it in the forefront of our minds.

If I might start from division 2 in the GMC booklet that we have available. Division 2 is Good Medical Practice from October 1995 and on page 8, paragraph 24, under the heading “Working with colleagues”, the following appears:

“You must not make any patient doubt your colleague’s knowledge or skills by making unnecessary or unsustainable comments about them.”

Sir, turning to the next division, divider 3 of the same bundle, Good Medical Practice, July 1998, page 10, paragraph 29 repeats that paragraph in the same form.

In Good Medical Practice for May 2001, which is division 4 of this binder, page 12 paragraph 35, the words are put in a slightly different way:

“You must not undermine patients’ trust in the care…”

THE CHAIRMAN: Page 13, I think it is. You said page 12. It is page 13. It is paragraph 35 but it is on page 13. I think you said it was 12.

MR PEARCE: It is on page 12 of the copy that I have got in front of me.

THE CHAIRMAN: I think we agree it is para 35, it is disagreement about the page number. Approved May 2001, issued September 2001. It looks like the same.

MR PEARCE: At the next available adjournment may I just check that because I have got two copies where it appears on page 12. Let me read what it says here and then we can tell whether at least the wording is the same. It may be a point of no significance whatsoever. What I am reading is:

“You must not undermine patients’ trust in the care or treatment they receive or in the judgment of those treating them by making malicious or unfounded criticism of colleagues.”

THE CHAIRMAN: The wording is the same.

MR PEARCE: I think it is a point of no significance although mild perplexity as to why page numbers should be different.

Sir, we say that in each case that paragraph is important and, as I said twice before and repeat again, robust criticism is one thing but this went far beyond that.

Sir, that concludes my comments by way of opening on the facts. It might be a convenient moment for a break. There are one or two matters of what is sometimes
called housekeeping - timetabling is a more accurate way to describe that, I think. Unless you particularly wish me to deal with them now, I will deal with them after the short break, if this is a convenient moment.

THE CHAIRMAN: I think this is a convenient time to have a break but before doing so, could I just check with Mr Morris that I have got it correct. 9c ii was not admitted?

MR MORRIS: Sir, it is not admitted. May I explain the basis of its non-admission. The allegations as it currently reads,

“In the letter you stated as follows:

ii. that Dr Thomas had stated that a ‘concentration problem is for messy kids’”

The concern is that it does not make it clear that that was a statement that he was reporting as having been made to him by the patient.

THE CHAIRMAN: Thank you very much. We will have a break now and we will reconvene at about five-past eleven.

The Committee adjourned for a short time

MR PEARCE: Sir, I had indicated that there were just one or two housekeeping matters. First of all, the first witness whom I intend to call is Professor Taylor, who I call as an expert witness. I have discussed the matter with my learned friend this morning and he quite rightly says - and quite understandably says - that he will have some difficulty in cross-examining Professor Taylor, part of whose evidence will be based upon what other witnesses have to say, until he has heard the other witnesses say it.

It is quite understandable that he should say that and we have therefore made the following arrangement, that Professor Taylor will start his evidence today - it is convenient for him to give evidence now by way of background and some little information about Ritalin in particular, risperidone and such like, some little information about monitoring and reference to some literature which has a general application to these issues, but without descending to the particularity of any of the charges at this stage. Then, Professor Taylor will be recalled later on in the case in order to complete examination in chief so that I can ask him to consider particular charges with which you are concerned and to allow my learned friend to cross-examine him.

Convenient as that is from our point of view, it has one slight problem which is that the only time that Professor Taylor can return - or the earliest that he can return - is next Wednesday.

I have discussed it with my learned friend. I think we are agreed that we will make it fit in that way. I appreciate that that is some way through the case and that there is quite a lot of other evidence to hear in the meantime.

THE CHAIRMAN: Mr Morris, I take it you agree with that?
MR MORRIS: I do. I am grateful to my learned friend for mentioning it.

THE CHAIRMAN: I assume that Professor Taylor, from what you are saying, is not going to be listening to the witnesses when he comes to be recalled and cross-examined?

MR PEARCE: No doubt any relevant information, however it is adduced, will be put to Professor Taylor so that he can consider what the witnesses have had to say.

THE CHAIRMAN: We will agree with that.

MR PEARCE: I am most obliged, sir. Otherwise, the witnesses I call are called to suit their convenience as far as possible. It means that we are somewhat higgledy-piggledy in terms of the order but I think I am right in saying that insofar as there is more than one witness on any particular head of charge or any particular patient, that two witnesses are called consecutively, so we are dealing with it patient by patient, albeit that it will not be in the same order as in the charges. I am sure that that will cause the Committee no trouble, but so that you understand that position now. It is very much for the convenience of witnesses who, of course, may either have attended or were available to attend in January and again I am sure you will understand that.

THE CHAIRMAN: Do these proposals have any implication for the potential eight day schedule for the case, or is it too early?

MR PEARCE: I think the answer is it is too early to say. I have touched on that with my learned friend but I think that it is too early to say. I would like to think it will have no effect on it. If it does, the greater concern will be Professor Taylor not being available until Wednesday of next week. Unfortunately Professor Taylor is one of those witnesses who did actually physically attend on the last occasion and was kept waiting, I think on the Wednesday of the first week - I may be wrong on that - for a good part of the day on the basis that it was not clear whether he would be able to give evidence or not. It is unfortunate, but there we are. Hopefully it will not delay us.

THE CHAIRMAN: We can now proceed, if there are no other housekeeping matters.

MR PEARCE: I am much obliged. I will call Professor Taylor, please.

PROFESSOR ERIC TAYLOR Affirmed
Examined by MR PEARCE:

Q Could you identify yourself to the Committee, please
A I am Eric Taylor. I am Professor of Child and Adolescent Psychiatry at the Institute of Psychiatry, Kings College, London and I am an honorary consultant child and adolescent psychiatrist at the Maudsley Hospital.

Q I am obliged. Could I produce your curriculum vitae, Professor Taylor? I thought when I first saw this bundle that it was a bundle of both the curriculum vitae and the literature and was alarmed to discover it is the curriculum vitae alone!
THE CHAIRMAN: This will be C9. *(Produced)*

MR PEARCE: I am much obliged. Can I ask you to confirm that this is your curriculum vitae, Professor Taylor?
A Yes, it is.

Q I am not going to go through this in any detail at all because, as we will see when we refer to some literature in a short while, you have written in this area with which we are concerned, that of ADHD. Could I ask you first of all to describe attention deficit hyperactivity disorder for the benefit of the Committee?
A Yes, of course. It is a condition that is characterised by high, inappropriate and impairing levels of some types of behaviour the children show enduringly. The particular types are being very inattentive, distractable, disorganised, chaotic, being very impulsive, not thinking things through, jumping to conclusions, getting things wrong, getting into trouble because of thoughtlessness and of being over active as well, as the name implies. The actual level of activity is seldom the most important problem. It is a condition in which there has been a great deal of scientific research and there are a number of different causes that affect it.

Q You mention the condition in children. What about the condition in adult?
A The condition in adults gives rise to much more scientific uncertainly. There is not the same kind of level of scientific research that has been done, at least until very recent years.

It is, of course, a matter of every day observation that people vary a good deal. Some adults are much more disorganised than other. The controversy has been about how to understand that and for some psychiatrists, including myself, a lot of those cases can be seen as the direct continuation of the childhood problem of ADHD.

For others - and probably for the majority of general adult psychiatrists in the country, they are best seen either as the result of another disorder, such as a kind of mild hypermania, as a sort of bipolar disorder, as part of a wider reaching issue, a personality disorder or as a way of talking about people’s problems that they have encountered in life and have lacked success, therefore overlapping with the issues of mild learning disability and specific problems such as memory difficulties.

So, there is an argument which I think the evidence has not completely resolved about how far ADHD should be recognised as an adult problem and a proper thing to treat in adult life.

My view is it probably is. The majority view is that it is not. As far as I know there are only two clinics under the NHS that deal with adult ADHD.

Q May I ask you about treatment for ADHD. Again, for the moment let us limit it to children where I think the diagnosis may be a little less controversial. What forms of treatment are considered by psychiatrists dealing with ADHD?
A Well, as the problem is recognised, there is first of all assessment that looks to see whether there are underlying problems that may be causing it, such as a learning disability or something of that kind. Secondly, it is a process of educational process,
advice and liaison with schools. Thirdly, there is a range of psychological treatment available of which, especially with younger children, parent training of the principles of behaviour therapy is of great value. The most effective therapies are medication - or the most powerful therapies are medication, of which the front line of drugs are stimulant medicines, drugs such as methylphenidate, dexamphetamine, drugs whose purpose is considered to be to raise the levels of available dopamine within the brain.

There is also a range of second line drugs that are used, typically used if the stimulants are not effective which do not have the evidence base, do not in general have the evidence base for the stimulants. One was licensed just last week, I think.

Other drugs that are used include antidepressants, for which there is limited evidence for some value. Drugs such as the motor tranquilisers, the neuroleptic drugs, such as Risperidone, for which there is not any trial evidence in favour, but which are used especially for the control of aggression, though their prime indication is for psychosis and a range of other drugs which, especially ones which have an influence upon the noradrenalin(?) system, rather than the dopamine system in the brain, drugs which would include clonidine.

You have identified Methylphenidate, of which Ritalin is a variety?

That is correct. There are several proprietary names and Ritalin is the best known.

Could I return to Methylphenidate for a moment and those stimulants. Could you explain in a little further detail how they are thought to assist in treating people with ADHD?

At the psychological level then it is thought that their main action is to help to correct the impulsiveness that children often show. That is to say, they are not sedatives, they are not tranquillisers, their purpose is to restore normal function. Their intention is to help performance in psychological tests and, more importantly, in real life, in education performance. Through giving children more time to plan ahead and think their actions it makes them less likely to be in impulsive trouble, it affects both the inattentive side and the restless side of the children's problems.

How is it thought to do that? You mentioned dopamine.

Yes, the best evidence is coming from assaying the levels of chemicals in the brain when the medication is given by comparison by when a dummy medication is given. Then what happens is they inhibit the dopamine transporter, which is the protein in the brain that combines with the dopamine and removes it from effective working in the brain.

So because it inhibits that molecule removes dopamine in the brain, they raise the effective level of dopamine concentration.

It is thought that that is related to the actual causes of ADHD because one of the genes which is weekly associated with ADHD is the one that helps to form that dopamine transporter molecule.

The other drugs, the second line drugs work in rather differed ways.

Risperidone is one of those?

That would work in a quiet different way. It is more of a damper down than a stimulant. Its purpose essential is to control, well, its license purpose is for the control of
psychotic illness, but in this context its key purpose is to be controlling aggressive behaviour, but that class of drugs of the neurolectics are antagonists of dopamine, they do not have helpful effects upon the attention side of the problems specifically, they are more like a general way of reducing the actively levels and especially the aggression levels of what the child is doing and they carry rather more hazards than the stimulants do precisely because they have a broader range of actions in the brain.

Q The matters with which we are concerned in heads of charges before the Committee cover a period from 1996 to 2003, predominantly in the late 1990s and around 2000. At that time was it easy to find psychiatrists who would be willing to treat children with ADHD with the use of drug therapy?
A By the late 1990s that was developing, yes. There was a gradual increase through the 1990s in the recognition of the problem in children. So I think it was in 1995 that Ritalin was reintroduced to the market having been withdrawn by its manufacturers for some years. The years subsequent to 1995 to 2000 saw a considerable increase and a good deal of controversy within the profession as well.

Q What was the nature of that controversy in general terms?
A Firstly as to whether ADHD should be recognised widely or narrowly. Whether it should be seen as a relative uncommon problem, affecting perhaps half a per cent of children, which was the definition of Hyperkinetic Disorder, which remains the official diagnosis in this country, or whether one should recognise more broadly the ADHD, Attention Deficit Hyperactivity Disorder, which is the term from the American classification, affecting more perhaps like four or five per cent of the childhood population. First of all there was a controversy of the recognition of the disorder. Secondly, and linked to that, there was controversy about the balance of psychological therapy as against medication; which you should give first. There still is some controversy about that. Most mental health services in the country do now have services for ADHD in children, but there still vary as to whether they began with the psychological treatment or whether they began with the medication treatment, though all would regard it as essential for children to have the availability of both at some point.

Q In terms of those two areas of controversy, you have had an opportunity to read a large amount of documentation relating to this case and also, I think, you have read Dr Cosgrove's published writings. Where do you understand Dr Cosgrove to lie in that controversy, first of all about Hyperkinetic Disorder as against ADHD, the broader or the narrower classification?
A Dr Cosgrove was a pioneer in the recognition and the introduction of stimulant medication for ADHD in this country. He was from the start a propounder of it. My understanding is that he would be taking the view that really medication is the sole answer to the problems of ADHD, which I would see as an extreme view. But certainly his position throughout has been one for the wide recognition of ADHD and the early and simpler course to medication is therapy.

Q Might I ask you to look in the Committee bundle, under division seven, page two, I am not in any way concerned with detail of the charge, this is a letter from Dr Cosgrove to Miss Samways, I am concerned with a point that Dr Cosgrove makes in the course of this letter he says, last paragraph:
“I am probably the most experienced specialist in the United Kingdom in the use of this Risperidone in children, having treated more than 500 young patients with it since 1993.”

Do you agree with that comment by Dr Cosgrove?
A Yes, I would agree that he has probably treated more children with Risperidone than anybody else. I would not necessarily agree that was a definition of expertise because, of course, it would be quite possible if that practice were wrong that it would be a wide experience of error, rather than a wide experience of correct practice, but I would agree that it is very likely that he treated more children than anyone else in the country.

Q May I now turn to dealing with some literature on the subject. Another two exhibits that I have here, (handed) the first one begins with an article by Cantwell.

THE CHAIRMAN: This will be C10.

MR MORRIS: Obliged, sir, and the second is headed “Practice Parameters for the Assessment and Treatment of Children”, etcetera. (handed) I take it this will be C11?

THE CHAIRMAN: Yes.

MR MORRIS: Professor Taylor, it might, I think, be most useful first of all to look at, I think it is prepared by you and Peter Hill, “An Auditable Protocol for Treatment of ADHD” which should appear in C10, the handwritten 313 in the bottom right-hand corner, co-written by you and Peter Hill?
A That is correct, yes.

Q When was this published?
A Dear me!

Q I cannot find it on the document.
A It will be in the CV. I think that was probably 1999. Let me check on that. 2001.

Q So this is a protocol that was published after most of the events with which we are dealing in the charges here?
A Yes, that is right, yes.

Q Over what period of time did you and Peter Hill write this protocol?
A Over about a year.

Q So what do you say about the application of this protocol to the current management of ADHD?
A Yes, I would think that this is intended as standards for current management in every respect except that is takes no account of the most recently introduced drugs.

Q We will in due course look back to earlier literature which may be more relevant to the standards in the mid/late 1990s?
A Yes.
Q Can I take us to various parts of it. Page 313 at the very bottom paragraph

“The recent large MTA treatment trial in North America has not yet been fully reported and the interpretation is proving somewhat problematic. Nevertheless on this and other recent work principles have merged which are important.

. Medication is best titrated against adverse and desirable effects rather than given on a pre determined milligram or per kilogram basis,

. Desired effects should include improved education achievement and social relations within the peer group as well as behavioural control.

. Psychological treatment adds only moderately to optimise medication dosage, but can be of value for selected targets,

. Psychological treatment reduces the dose of medication occasion required.”

Since this was written have developments altered, where those principles have correctly emerged from MTA treatment?

A I think they would still stand. I think there would be no controversy, except, perhaps, about the third, which is that there would still be room for debate with some people considering that psychological treatment is of considerable value in its right and can add to optimised medication dosage. Further analysis of the study has suggested the best results are obtained when you do have a combination of medication and behaviour therapy.

Q Further down on page 314, the fifth full paragraph:

“Although medication is the most powerful treatment in terms of effect size, not all cases will need it, not all families accept it and not all children will be suitable for it. Psychological intervention may prove sufficient. If it is not, there is evidence for the effectiveness of an individual constructed elimination diet.”

You go on to deal with diet issues. But there emphasising a point that you have already made that medication is the most powerful?

A That would still be the view. There has been a recent development of consensus European guidelines which suggests that medication should be the first therapy for the most severe cases, those most closely approximating to the rather narrow definition of Hyperkinetic Disorder, and for the wider group there are options in therapy negotiation between familiar and prescribing professionals about which kind of plan you start with.

Q At least in so far as we are dealing with the more severe cases the more recent thinking has tended to back medication; Dr Cosgrove's type of approach against those who might have taken a different approach?
A  Yes, yes.

Q  The bottom of page 314 to flag this up:

“We have omitted consideration of classroom management techniques because these are best implemented by Education rather than Health Service professionals. They have been shown to be effective and need to be deployed as a component of treatment.”

Again do you stand by that comment?
A  Yes, that would be even clearer now, yes.

Q  Moving into the management protocol that you refer to here, you start from page 315 and running on you talk about assessment, obtaining base lines, on page 316 you indicate physical examination towards the top of that page and a number of tick boxes in respect of that kind of examination. For what purpose are you saying that examination should be carried out?
A  For two key purposes. Perhaps the most important is following the future course of medication, for detecting unwelcome effects which the medications may have upon growth and upon the cardiovascular status. Secondly, for detecting other problems which may be significant in and child development, which may be associated with ADHD, such as in (Inaudible), which though not necessarily a part of is quite often associated and may well be a reason for considering physiotherapy, occupational therapy or the like in the management of the whole child's problem.

Q  Moving on if we may, that is under the heading assessment, we move on to treatment on page 317, various basic handling framework, for example, referred to there, basic handling practices:

“If this is insufficient, proceed to consider medication.”

Over the next page, page 318, just over halfway down, “Obtain baselines”, and you there indicate amongst other things weigh and measure height, plotting on growth chart. Is that for similar reasons to those you have outlined already?
A  Yes, it is, it is emphasising at the point where you start medication you need to make these measures again in order to have an up to date baseline for evaluating continuing effects. It is only minority of children whose height and weight are affected by medication, but it is a significant minority and it is one of the concerns about the use of the drugs that gives rise for caution.

Q  Then you would consider and might move to titration of methylphenidate, Ritalin we see at the bottom of page 318. On page 319 and certainly those references to monitoring now, perhaps a sixth of the way down, the paragraph beginning:

“Monitor with regular questionnaires from parents and school. See below for checklist. Need to establish

a. symptomatic and behavioural gain
b. performance improvement gain (academic, peer group)

c. adverse effects.

After 2-4 weeks (depending on availability of teacher questionnaires) review personally and enquire about beneficial and adverse effects.”

You talk about possibly then increase in dosage.

“After approximately a further four weeks (i.e. 6-8 weeks from baseline) review personally and enquire about beneficial and adverse effects.

You talk about the possibility of increasing dosage. A little further down:

“Continue to monitor at home and school with questionnaires. Ask specifically if child is dazed or perseverating (dose-related side-effect). After approximately two further weeks (i.e. 8-10 weeks from baseline), consider

1. whether effect obtained in health and education gain terms

2. if so, and if child weighs more than 25kg, consider increase to 20mgmorning, 20mg midday, 5-10mg mid-afternoon.”

Just so we understand where we are up to there, that in terms of dosage then, you are considering a total dosage of perhaps 45 to 50 milligrams at that stage?

A Yes, that is correct. One only gets to that point if this considered to be still room for improvement. That is to say, for most children there will have seen substantial benefit on the lower doses. So that in the large MTA trial, that you referred to before, the average daily dose was of the order 30 milligrams a day, three doses of ten milligrams each. So it is only if there is inadequate improvement at that point that one goes on the higher dose level.

Q Yes. Just in passing so that we note it, footnote 20, which is on the line:

“Adjust afternoon dose according to difficulties or discontinuation rebound reaction”,

Footnote 20:

If CVS is more can add clonidine 5—250 micrograms as evening dose, utilising drowsiness side-effect, increase dose with caution.”

What then is the purpose of the clonidine being added in that situation?

A In that situation it is to counteract one of the possible problems that the stimulants can produce which is that the child is losing sleep and is kept awake at night. When that appears one makes other advice first. Perhaps one adjusts bedtime routine. One introduces bedtime routines. Make sure the child is not hungry when they go to bed. Common sense measures of that kind. If they do not work, then what we are suggesting
at that time was that clonidine was a suitable sedative to be using. Since then that would probably have changed. Nowadays most practitioners would now use the most recent technique of giving melatonin as the sedation.

Q I am sorry, I jumped back in time:

“After approximately two further weeks (i.e. 8 – 10 weeks from baseline)”

We read some of that and the possibility of increase to 45 to 50 milligrams per day.
A Yes.

Q Further down again:

"Enquire about desired and undesired effects at school and home

Monitor home and school with questionnaires monthly until 6 months, then 6 monthly

Review personally, weighing and measuring height at least six monthly”.

Now in general terms, without dealing with the individual patients for a moment, it would appear that or may appear that in a number of cases Dr Cosgrove was reviewing patients over the telephone. What do you say about telephone monitoring and review?
A Well, there is a place -- as part of the overall package some of the monitoring can indeed be done by telephone, and that is especially the case when parent and families are living at some distance from the prescriber as would have been the situation in this case.

E Q Yes, precisely so. Yes.
A However, there are some things that you cannot get solely from parental report. In particular parents do not necessarily know about problems at school, because they are reliant upon teachers telling them and teachers may not want to stress the negative that is happening with a child, and there are some things that may only appear on the examination of the child. We have mentioned perseveration and being dazed. The issue there is that for a minority of children they may appear to be much improved, in the sense that they are stiller and they are quieter, but that is not accompanied by true improvement in cognitive performance because in effect they are over-faced. They may be staring at the teacher, but they may not be taking in what the teacher is saying. So, it is possible to have a rather subtle effect at that point for which you need to see the child yourself. You cannot just tell by report, because everybody may say, "Yes, things are much better".

G Q What about physical monitoring and review in terms of weight, height measurements and such like?
A Yes, these do not -- I think these do not require specialist investigation.

Q Yes.
A So, they are NICE recommendations - the National Institute for Clinical Excellence recommendations - and it is quite possible to set up a shared care system in which the specialist has initiated the treatment and established the early dose, but then there is a
shared care system with General Practice in which the family doctor would then be the person who was monitoring the height, the weight, the blood pressure and the pulse rate.

Q  Yes.
A  And the ECG if that were necessary in the individual cases.

Q  Yes, yes. And turning over on to the next page I think, essentially having reached those levels of dosage you have referred to, then in this algorithm or protocol you would consider substituting dexamphetamine for methylphenidate at this stage?
A  Yes, yes.

Q  Now, as indicated, published in 2001 and so not something that Dr Cosgrove could have available to him at the relevant time. Do you say, or what do you say though about the standards there referred to in terms of monitoring? The initial investigation and monitoring?
A  Yes. Well there is discussion within the profession, and some areas and some clinics have taken the view that the frequency of monitoring that is called for here is higher than can be delivered with resources available and that sometimes stakeholders such as the purchasers of service need to decide that a lower level of monitoring is necessary. And so I think that is against the evidence, because I think that the evidence is that there is a proportion - a sufficiently high proportion - of children who will develop either adverse psychological effects or adverse physical effects that that does need monitoring. And there is very good evidence that the more carefully you monitor the dose and the more carefully you get the dose correct for the child, which may mean a small dose for some children and a large dose for others, the more you individualise the dose to the child that makes a very big difference to the quality of response the children obtain.

Q  Yes.
A  So, if anything I think the evidence it would be in favour of even more detailed monitoring than is in this protocol.

Q  Yes.
A  But there is a compromise to make between what is best for the children and what is affordable.

Q  Yes, I understand. I understand. Now, could I then turn to some older literature that may tell us a little about standards in the mid to late 1990s. First of all, can I look at Professor Cantwell's article, "Attention Deficit Disorder: A Review of the Past 10 years", which is Page 286, the first page I think of C10. In the bottom left-hand corner of Page 286, we can see that this was accepted for publication on 12 September 1995 and we can see that Dr Cantwell is Joseph Cantwell, Professor of Child Psychiatry at UCLA Neuropsychiatry Institute?
A  Yes. He was probably the most distinguished figure in the field, but he died recently sadly.

Q  Right. Now, there is a great deal of information in this article and I just want to take you briefly to one or two parts of it if I may. Could I ask you first to look at Page 292, please, and again all references are to the handwritten page numbers. In the
left-hand column, the final paragraph, beginning this:

"The primary psychopharmacological agents used to treat ADD are the CNS...",

And that is central nervous system?
A Central nervous system, yes.

Q

"... stimulants. The prototype drugs are dextroamphetamine methylphenidate..." (which we know is Ritalin) "... and pemoline. There are a number of amphetamines including methamphetamine and dextroamphetamine, but dextroamphetamine probably enjoys the greatest use. Methylphenidate is probably used more than any of the other stimulants. At least 70% of children will have a positive response to one of the major stimulants on the first trial. If a clinician conducts a trial of dextroamphetamine, methylphenidate, and pemoline, the response rate to at least one of these is in the 85% to 90% range, depending on how response is defined".

At the top of the next column:

"While it is clear that the medications target classroom behavior, academic performance, and productivity, there is also good evidence to show that ADD ...",

and I am sorry that I have read through this without noting that subtle distinction between ADHD and ADD. Perhaps just assist us with that, if you would be so kind?
A There was a change in the classification system. The disorder that had previously been referred to as ADD (Attention Deficit Disorder) later became known as ADDH (Attention Deficit Disorder With Hyperactivity), and most recently in the most recent change of the classification system, the DSM4, it became known as ADHD (Attention Deficit Hyperactivity Disorder). Going along with those changes in name there were minor differences in the wording of how the criteria for it were expressed, but I think that these are differences without very much significance.

Q Yes?.
A They have been attempts to refine the diagnosis, but they are referring essentially to the same condition.

Q I am obliged. I am obliged. So, if we just pick it up again there in that sentence:

"... there is also good evidence to show that ADD children with oppositional and conduct symptomatology and aggressive behaviour also respond positively in these areas as well".

A little further on:
"The main message is that stimulants are not 'school time drugs'. They should be used throughout the waking day and on the weekends as well".

And a little further on:

"Side effect profiles may be better for one child with one drug than another, but in general all stimulants share side effects of decreased appetite, insomnia, stomachache, headache, and irritability. Most side effects will dissipate with time and many can be managed with various types of manipulation".

Just pausing there for a moment, do those comments that I have there read out reflect then standard thinking at the time of this article?

A  Yes, yes.

Q  Could I also turn you to Page 294, again in the same article, and just again I want to ask you whether you think that the passage I am now going to read reflects good and up-to-date thinking at the time of this article. The left-hand column:

"It is now accepted that a multimodal approach to therapy that uses both psychosocial intervention and medication has the greatest chance of alleviating the multiple symptoms and domains of dysfunction with which ADD children present. Medical treatment and psychosocial treatment have complementary effects. Thus a wider range of symptoms may be treated than with either intervention alone. Psychosocial intervention may improve symptoms during the period of time that medication has worn off. The use of both interventions together may lead to lower medication dosage and a less complex psychosocial intervention program than with either treatment alone"?

A  That was definitely the standard view in American practice at that time. In English practice at that time, as we have said, probably most Child Psychiatrists would not have accepted that medication had as large a role as was being put in that, but it represents the mainstream of American type thinking - of ADHD thinking - at that time.

Q  Right.

A  And there were many other things at the time that went in support of it. The American Psychiatric Association gave evidence to Congress and so on that that would be the standard view.

Q  Now may I move on from that document to the next one in this Exhibit C10, Page 296, "Clinical guidelines for hyperkinetic disorder", again I think with your name at the top of the list of authors of this article in "European Child & Adolescent Psychiatry". Could you just explain what this article represents?

A  Yes. This was an attempt to be reaching a consensus about the more European style of practice, which is perhaps the more conservative style especially with regard to
medication than the American style.

Q       Yes?
A       And so this was drawing upon people from psychiatry and psychology and neurology from different European countries, and it was a series of meetings, it was reviewing the evidence - the evidence base - for the different forms of treatment available and it was trying to come to consensus recommendations on the basis of that.

Q       Yes.
A       And the process has recently been repeated for an upgrade and that is in press at the moment.

Q       Right, right. And you have mentioned Hyperkinetic Disorder earlier on, that classification, but just again so that we understand why it is referring to Hyperkinetic Disorder rather than ADHD?
A       Yes. Well essentially because Hyperkinetic Disorder is the term that is used in the international classification of disease, which is the one that governs official practice and indeed governs -- it is the one that is officially adopted nationally here.

Q       Yes.
A       The term that is used there is Hyperkinetic Disorder and ADHD is the wider term used in the American classification, but in practice most clinicians usually use the term ADHD rather than Hyperkinetic Disorder. There is a confusion and often a confusion in practice about whether people then are referring to a broad ADHD or a narrow ADHD definition, but I do not think that particular problem is going to be germane to the case.

Q       No, I understand. Turning if I might to Page 303, handwritten 303 in this article, there is a section headed "Psychopharmacological treatment", and I think it is clear if one analyses the lead-up to this that you are here dealing with the position of children? I think you deal separately with the issue of adult pharmacological - psychopharmacological - treatment later on and we will come to that?
A       Yes.

Q       Just if I might read just part of this paragraph:

"There is a massive evidence base from controlled trials for the effect of methylphenidate over treatment periods up to a year and in doses of up to 60 mg daily. The effect size is large: in excess of 1 standard deviation",

and you go on to deal with two other stimulants and something about the nature of the testing. Then at very or nearly the very bottom of the left-hand column:

"The effects of stimulants are not only on hyperactive behaviour; they also produce beneficial results in tests of cognitive performance, academic productivity, oppositionality, and social interactions with parents and peers".

And then a little further down, or in fact the very bottom of the right-hand column of
Page 303, you talk about dosage:

"The effect is brief and repeated doses are necessary. To obtain symptom control over a 12-hour day, three doses are usually needed; but sometimes practical considerations dictate a twice daily dose, and the frequency and dose should be titrated individually according to clinical response. For children of 6 years or more a good schedule for the 1st week is 5 mg thrice daily. If the response is less than optimal, the dose can be increased in the second week, e.g. to a thrice daily schedule of 10 mg, 10 mg and 5 mg, and then if necessary to 15 mg, 15 mg and 5 mg. For children weighing more than 25 kg then one can proceed to a further week of 20-20-10-mg. The best dosage is then judged, the child continued on it, and times of administration adjusted to give the steadiest control. In most circumstances, we regard the maximum daily dosage as 60 mg; but this is not established by trial data".

Now pausing there and that 60 mg figure, and we will see another figure appearing a little later on, could I ask for your view on the maximum daily dosage?

A  Yes. I would now put it in terms of mg/kg doses, rather than absolute doses.

Q  Yes?
A  And that would imply that for some larger people the dose was a little higher than that.

Q  Yes.
A  So, we would now say that the maximum dose was 0.7 mg/kg per dose on the basis of two or three doses each day.

Q  Yes.
A  Nobody in the States uses doses that are higher than that.

Q  Yes.
A  Partly because of legal concerns.

Q  Yes.
A  And so, partly because of that, we do not have very much knowledge of what happens with the higher doses.

Q  Yes.
A  We do know that the increase of adverse effects is greater the higher the dose, not surprisingly.

Q  Yes.
A  And the experience of those people who have used high doses is that you get no benefit in terms of increasing dosage.
A And so the ceiling, which would work out at about 60 mg a day for the average ten year old child - more for a teenager.

Q Yes?
A That ceiling is established really by custom and practice, rather than by rigorous trial evidence. And it is possible occasionally to go up above that dose. I think the most I have ever prescribed is 85 mg per day in an older teenager.

Q Yes.
A One concern -- several concerns come in with the higher dosages, especially the increasing risk of hidden adverse effects in the mental state. For instance, hallucinations start to appear and children may very well not speak about them spontaneously. The best dose for cognitive performance - for understanding, for schoolwork and that kind of thing - may very well be lower than the best dose for reducing behaviour. So that if you have the highest dose to increase behaviour - I am sorry, to improve behaviour - that may not be in the best interests of the child's overall development.

Q Yes.
A We have also learnt since then that tolerance does develop to the medication in the course of the day, so that high doses may have a counterproductive effect in that each day some tolerance to those doses develops and then each night, when you are off the medication, then that tolerance is withdrawn. So that with high doses you may get into very much diminishing returns for beneficial effects, but not for adverse effects.

Q Yes, thank you. Well, that is helpful. I mean, just we bear in mind this. That it is no part of the charges of course against Dr Cosgrove that any particular prescription or any particular dosage here was excessive, but when we deal with individual patients in due course - probably on Wednesday of next week as I have indicated - I will ask you to consider further the particular dosages that may have been prescribed in particular cases.
A Yes, exactly. I do not think that one should. I don't think that it is appropriate to be putting an absolute ceiling ---

Q Yes?
A --- if an individual child is doing very well on the higher dose and is having no adverse effects, but I think it is quite proper to make individual decisions about the child's response.

Q I am obliged for that indication. How though, if at all, does a higher dosage bear on the issue of monitoring?
A Well, because adverse effects increase with increasing dosage, then when you are going above standard levels then essentially you are in tiger country. You are in uncertain waters. You know the adverse effects are greater, but it is hard to quantify that. So, essentially what that calls for is that you need to be much more careful with it. An enhanced level of monitoring would be indicated. And the indications for monitoring, that are in the practice guidelines by Professor Hill and myself that you mentioned before, those are intended only to apply to the ordinary range.

Q Yes.
A Not to a very high dose.
TranscribeUK 020 8614 5799

Q I understand. And, just referring to this European-wide consensus or documentation that we were at, in terms of what is said about monitoring there could I refer you to Page 304 that again clearly is following on from the heading about psychopharmacological treatment. In the right-hand column, under the heading "Precautions and monitoring":

"We regard all the stimulants as contraindicated in schizophrenia, hyperthyroidism, cardiac arrhythmias, angina pectoris, and glaucoma, and, of course, when the drug has previously caused hypersensitivity. Caution is needed in the presence of hypertension, depression, tics (or a family history of Tourette's syndrome), epilepsy, pervasive developmental disorders, severe mental retardation, or a history of drug dependence or alcoholism.

Monitoring should include recording blood pressure and pulse (at each adjustment of dose, then every 6 months), height weight and appetite (6 monthly) with maintenance of a growth chart; tics, depression, irritability, lack of spontaneity, withdrawal, and excessive perseverance at every visit".

That ethic rather ties in with the protocol that you have referred to earlier in terms of monitoring?
A Yes, it does, and like that it was a consensus decision. Many of us on that panel were wanting a more frequent dosage, but this was what was considered feasible.

Q Frequency of monitoring?
A A greater frequency of monitoring, yes.

Q I understand, yes.
A But this was what was considered a sort of minimum acceptable standard.

Q Yes. And I mentioned that adults were considered separately here, and I think at Page 305 there is a heading "Adults":

"Recently, data have appeared on effectiveness and dosage for adult patients. Some well-controlled studies have shown that adults are sometimes helped by methylphenidate"?

A Yes.

Q So, there we have evidence in the 1990s of adult treatment using methylphenidate?
A Yes.

Q Of studies and research into that. I am obliged for that. Now, if we may move on to page 327 in this bundle - 327 and following. That represents, I think, an extract from a text book called Paediatric Psychopharmacology edited, I think, by Professors Amman and Whaley. Is that correct?
A Yes.

Q On page 327 for the moment, under the heading “Usage”, “When to Use...
Medication”:

“The decision to use stimulant medications with children should not be made lightly, despite the efficacy of these medications and their relative safety with children. As we have noted elsewhere the diagnosis of ADHD should not constitute automatic drug treatment. We suggest following several rules as aids in making this decision.”

Just so that I understand this, in this range of opinion that you say there was, particularly in the 1990s, as to psychological therapy on the one hand and pharmacological therapy on the other hand, where does this textbook lie?

A This is the pharmacological end of the spectrum. This is representing what would be the mainstream American view in the widely prescribing situation.

Q Yes. At page 329 - and I am sorry to pick around a little bit like this but we can all go away and read it all if we need to, but I am hoping to draw out those parts of the literature that are most relevant. On page 329, again the hand-written 329, one sees the heading, “Prescribing and Titrating” and the second paragraph:

“The first choice of medication is usually methylphenidate because of its greater documentation in research, proven efficacy across a wide age range and greater dose-response information.”

Again, we see I think that would appear from this literature a fairly widely held view that methylphenidate is the first choice if one is using drugs. Over on the right-hand column at the very top, below the table, at the top of the text on the right-hand side of 329, talking about dosages:

“Some investigators have reported total daily dosages of as high as 60 to 70 mg, although we rarely go beyond 30 to 40 mg per day in our clinic.”

So again, without saying there is a ceiling - and I am not contending that - but again we see evidence here of 60 or slightly over 60 as being a typical maximum dosage?

A Yes, that is right and the more or less equivalent, modern version, of 7 mg/kg, is not a thing that American practitioners would go beyond.

Q Yes. Could I ask you to look at page 331?

“Maintenance on Medication

a. Assessing Progress

Once a child’s optimal dosage is established, then some, preferably all, of the above measures should be collected periodically throughout the school year to evaluate the need for dosage adjustments or the onset of side effects.
The vast majority of the questionnaires need only be readministered every several months or so. However, it is usually a good idea to review items from the Side Effects Questionnaire each month when the parents call to obtain another prescription. In addition, at each monthly contact (usually by telephone) a checklist of questions is reviewed with parents to assess continued drug efficacy."

We are, as I think you have already indicated, talking about the United States here in terms of assessing progress. How does this kind of practice compare with what was considered usual in the United Kingdom at this time?

A I think the disagreements were essentially about when you started medication. Once the medication was started, then it would be the same recommendations. It would be the same view here. The disagreements were about who should have it, not how it should be given.

Q I understand. Further down under “Side effects”:

"c. Side Effects

These should be asked about at every monthly contact, and the parents should be informed in advance about the presenting symptoms of any serious side effects, e.g. depression, weight loss, induction of tics or, with pemoline, hepatic damage. For children receiving pemoline, at six month intervals or whenever suspicions are prompted by symptoms, blood should be drawn for liver function tests given the finding that this drug may adversely affect liver functions.”

Clearly that is not relevant here.

“This is no substitute for a review of possible presenting symptoms of such dysfunction at each monthly visit.

d. Reassessment

Approximately every 3 to 4 months that a child is on medication, it is advisable to administer a more thorough follow-up clinic examination. During this time height, weight, blood pressure and heart rate can be recorded to determine potential side effects and any blood tests done. Parent and teacher ratings should be collected concurrent with this visit as well.”

It may be a slightly different interval but it is, as I understand it, the same kind of review?

A It is the same kind of review. That is essentially what would be happening in office practice in America, where family doctors are very often treating the ADHD themselves, so it would not be quite the same as in clinical practice over here. We would
expect more of a partnership between the specialist clinic and the family doctor, so it may be more relevant to private practice over here than to NHS practice, but essentially it is the same consideration. Here they are, for instance, talking about the monthly visit to the clinic and some of this might very well be done over here by the monthly visit to the family doctor with the clinic seeing every six months rather than every month or every three months.

Q Yes, I follow. Can we finally refer to the American Practice Parameters, the separate document that is exhibit C11. This, just to keep us all on our toes, does not have the hand-written page numbers on it. It has the page numbers that end with the letter ‘S’ and I shall refer to those typed ones in the bottom right-hand corner.

At the bottom left-hand corner I think we see that the copyright date of this article is 197. What do these Practice Parameters represent, Professor Taylor?

A These represent the sort of consensus about American practitioners comparable to the way of going about the European consensus that we saw earlier. It was being done under the auspices of the American Academy of Childhood Psychiatry.

Q Could I ask you to look, please, at page 95S. Perhaps rather hidden in the top left-hand paragraph half way through - I do not want to read all of it but a little over half way through that paragraph we see the sentence, do we not:

“The usual range for methylphenidate is 0.3 to 0.7 mg/kg per dose, rounded to the nearest 2.5 or 5 mg?”

A Yes.

Q That confirms the point you were making earlier about American practice and the dosage?

A We have now followed them in terms of mg/kg doses rather than in absolute doses.

Q I understand. Could I ask you to look, please, slightly earlier in this document at page 92S. We see in the left-hand column:

“Monitoring Medication Efficacy

Multiple outcome measures are essential, using more than one source, setting and method of gathering data. Premedication baseline school data in behaviour and academic performance should be available. The clinician should work closely with parents on dose adjustments and should obtain annual academic testing and frequent reports from teachers. A brief checklist such as the CAP profile is invaluable in obtaining teachers’ reports of medication efficacy. A practical schedule includes weekly ratings from teachers and two ratings per week from parents: one for Monday through Friday and one for weekends. Curriculum based measures and academic performance ratings are useful for monitoring progress in
academic subjects. Measures of academic productivity and accuracy administered in the office, such as brief readings and maths tests may be useful in assessing drug effect because of their similarity to tasks expected of the child at school. Protocols have been developed using direct observation and other measures in the school setting for determining in the optimal dose for children with ADHD who have normal IQ and for children with mental retardation and ADHD. A structured side effects checklist can be used…”

There, as I understand it, emphasising the importance of review on the academic side?
A Yes, that is correct and again, in principle, similar considerations would apply over here, though I think we would not be able to get quite the same frequency of involvement from teachers as would be the case in the United States because of the rather heavy loads on teachers that are already there in terms of the educational system, but certainly teacher reports are essential. I think the weekly report would be a council of perfection over here.

Q Following on from that, again, on page 92S, headed “Stimulants” there is a long passage, none of which, you will be pleased to know, I am going to read, which actually includes that reference to maximum dose. There is a long passage dealing with the stimulants and possible side effects of those stimulants. It deals with dosage in considerable detail, does it not?
A Yes.

MR PEARCE: I will pause with Professor Taylor at that point, sir on the basis, as I say, that I will proceed to deal with individual patients and individual charges in due course. Rather dry background setting there but hopefully of some assistance to the Committee and introducing the literature.

THE CHAIRMAN: Thank you. I know that we have not completed the taking of evidence form Professor Taylor but we are getting into a slightly unusual situation. On the basis of the evidence led so far, Mr Morris, are there any points that you want to cross-examine Professor Taylor on?

MR MORRIS: Sir, no. I prefer to reserve my cross-examination until next week.

THE CHAIRMAN: In that case we will pause in hearing evidence from Professor Taylor. We can excuse him for the present but I would remind you, Professor Taylor, that you remain under oath until we meet again next Wednesday.

MR PEARCE: I am much obliged, sir. It is my hope that my next witness was here. She was not actually when we came into the Committee room but that came as no surprise to us. We anticipate she will have arrived in the meantime. I wonder whether you would just allow us a few moments to speak to her and to confirm that she is here first and then speak to her and come back and call her.

THE CHAIRMAN: Certainly. Roughly how much time are you requesting? Is it
sufficient time that we can justify it for the Panel to go elsewhere?

MR PEARCE: In this building, yes. There are advantages for you but disadvantages for us in this building. I think you are relatively close now compared to as you were before. We are a lot further than we were before. I think five minutes, sir.

THE CHAIRMAN: That is fine. We will have a break just now.

THE LEGAL ASSESSOR: Perhaps if I could just give the standard advice as this is the first adjournment we have had since the beginning of the evidence. My advice is that you do not discuss the evidence amongst yourselves during the adjournment. This is to avoid discussions taking place between the totality of the Committee. It is quite important that when you do consider evidence, you all consider it together.

The Committee adjourned for a short time

MR PEARCE: I am obliged, sir. I call Miss Wendy Samways, whose evidence relates to charges 7 and 8.

WENDY ANNE SAMWAYS Sworn
Examine by MR PEARCE:

Q Can you give the Committee your full name, please?
A Wendy Anne Samways.

Q Miss Samways, what is your current occupation?
A I am Complaints and Patient Advice Liaison Service Manager for Oxfordshire Mental Health Care NHS Trust.

Q Were you in that post in September 2000?
A I was Complaints Manager at that time.

Q There should be a bundle of documents to your right. Could I ask you to look in that bundle under tab 7? Page 1 of tab 7, we see a letter dated 29 September 2000 with your name at the bottom of it?
A That is correct.

Q Is this a letter that you wrote?
A It is indeed, yes.

Q Just, firstly, so that you understand, we are using anonymised names for patients in the course of the hearing but in fact the anonymised names or letters are different to those that appear in the correspondence. The particular patient with which we are concerned here is being called Patient E?
A OK.

Q So that you understand. Just first of all, so that we can read through this letter:

“Dear Dr Cosgrove,
Re Patient E

I would be grateful if you could provide me with copies of any medical records that you hold regarding E. This Trust is, with the help of an independent expert, currently reviewing the way in which we manage E’s care and treatment following his referral to the Trust’s Department of Child and Adolescent Psychiatry and it would be helpful to have any information from you which would aid this review. We will, of course, meet your reasonable costs for the photocopying of the clinical notes.”

Now, so that we understand the background, how did it come about that the Trust was carrying out a review of Patient E’s treatment?

A We had received a complaint from the parents some time previous to that and had had several attempts at trying to resolve it through local resolution. After a meeting between myself, the parents and the Associate Director of Clinical Governance, we all agreed that it would be appropriate to have an independent expert review the care and treatment and the family at that time were in agreement with that.

Q To what did the care and treatment relate? To what condition did the care and treatment relate in patient E?
A He had been diagnosed with ADHD.

Q In general terms do you recall what the complaint was about the care and treatment?
A There were several aspects to the complaint, as far as I recall. Failure to diagnose ADHD, failure to adequately provide care and treatment for patient E and lack of support for patient E and the family in general, is my recollection.

Q You indicated that the parents agreed - patient E’s parents agreed - to the Trust instructing an independent expert?
A They did.

Q Who had the Trust instructed, or who were they proposing to instruct?
A Dr Kenyon.

Q Do you know what Dr Kenyon’s field of practice is?
A Yes, she was a child psychiatrist who had some expertise in ADHD.

Q Could I ask you then, please, to look at pages 2 and 3 in division 8. Was this a letter that you received from Dr Cosgrove in response to that letter of 29 September to which we have referred?
A Yes, it is.

Q I have already read this letter out, I think, in full to the Committee this morning, so I do not think we need to read it again. Can I ask you this. From your involvement as Complaints Manager at that time, as far as you were concerned, was the investigation and
review that was being carried out, in the words used by Dr Cosgrove, “a cover-up of grossly inadequate care” that the child had received?

A No. It was not. We were trying to resolve the concerns and the parents had agreed to have an independent review. We had selected a consultant child psychiatrist who was not known to us at all. We had gone to a firm of solicitors and asked them to recommend somebody and then we had asked the family, the parents, to approve or not that choice. We do not - my organisation, Oxfordshire Mental Health NHS Trust, works hard to try and resolve complaints and I would not be in that position if I thought that we were attempting a cover-up of any sort.

Q Thank you. If you would wait there, Mr Morris on behalf of Dr Cosgrove may have some questions for you.

Cross-examined by MR MORRIS

Q Miss Samways, you say the parents agreed this form of review?
A Yes.

Q Do you have any documentation in relation to your dealings with the parents in this regard and the fact that you put to them the name of the proposed independent reviewer with their agreement?
A I cannot recall that. I do not have the file with me today. What I do recall is that we went to meet the parents at their home, that we spent a considerable amount of time with them, a letter was sent, I cannot recall who from, I would either have been myself, the associate director of Clinical Governance or the Chief Executive, noting our meeting with the parents and the outcome of that. I liaised quite closely with the parents at that time about who would carry out the independent review. I cannot remember if that was done in writing, it would be my normal practice but I cannot remember because it was such a long time ago.

Q If I were to suggest to you that the parents did not want this form of review and were not happy with it, what would you response to that be?
A Well, that is not how or what they said to us, I mean, when we met with the parents it was clear they were unhappy, they were appeared to have had quite a difficult time, we were grateful to them really for continuing to engage with us in this process. They had been offered the opportunity to follow the NHS complaints procedure and go to an independent review panel, but they wished to pursue this option first, whilst still retaining the right to have an independent review panel if they wished.

Q Their concerns, I think you have outlined them, were that the failure to reach a diagnosis of ADHD for too long a period of time. Is that right?
A That was one of their concerns.

Q The subsequent care and treatment which was offered to their child in relation to that?
A Yes.

Q And the lack of support given to the family to help them cope with his behaviour and illness?
A Correct.

Q It was that that triggered the review. Can you help us with this, I do not know to what extent you were involved with the review itself that was conducted by Dr Kenyon, did she see the parents?
A I do not believe so, no.

B Q Do you know of any reason why that is so?
A Yes, as far as I can recall that was not part of what we had agreed with the parents. It was to be a review of the documentary evidence, i.e., the medical records and any other records that we could provide, so it was not about meeting with the individuals, Dr Kenyon did not meet with any of the doctors that had been involved in treating care either.

C Q Were the parents content that the review went forward on that basis, that they would not have the opportunity to speak to the reviewer?
A They did not express to the contrary.

MR MORRIS: Thank you.

Re-examined by MR PEARCE

MR PEARCE: One or two matters arising out of that, if I might, Miss Samways. You made mention of the independent review panel. How did the review you were carrying out differ from an independent review panel?
A We had offered -- independent review panel is, if you like, stage two of the NHS complaints procedure and there is a clear process to follow in setting up -- in requesting and the granting of an independent review panel. In offering an independent expert review, if you like, of the documentation we were still at that stage engaging with the family at the first stage of the complaints procedure, that is local resolution. The family, as far as I was aware, understood this and I believe one of the letters sent from the Chief Executive noted that if after that review, if you like, they were still unhappy day could request an independent review panel in line with the NHS complaints procedure.

Q You were asked about the parents attitude to not being spoken to by Dr Kenyon. When this independent expert review was being established, were the parents made aware that Dr Kenyon would not be speaking to them?
A I cannot actually recall. As far as I can recall, my understanding certainly, and I am sure it was the same of the parents, that this was a review of documentation rather than a meeting with lots of people. That would be carried out by an independent review panel in stage two. I was sure that we made clear this was a documentary review rather than meeting with individuals.

Q Before you received this letter that we see at division seven, pages two and three, had anyone expressed any concern that you were aware of about the nature of the review that was being carried out at that time?
A No. Not as far as I was aware at all.
MR PEARCE: I have no further questions.

THE CHAIRMAN: I will check if Members of the panel have anything. There are no questions so that concludes your evidence. Thank you very much for coming to assist us.

MR PEARCE: In sharp contrast to events in January we are proceeding too quickly now, sir. So much so that our next three witnesses we have are due to attend at 2 o'clock, but certainly they were not here when we were outside earlier. I wonder whether you would consider taking an early lunch on the assumption that they are here early?

THE CHAIRMAN: We will agree with that. We will break now and recommence, or try to recommence at quarter to two. Thank you.

The Committee adjourned for lunch

MR PEARCE: I am obliged, sir. Dr Holme, please.

CHARLES OLIVER HOLME sworn
Examined by MR PEARCE

Q Could you give the Committee your full name?
A Dr Charles Oliver Holme.

Q What is your current post?
A I am a consultant paediatrician and the Royal Devon and Exeter Hospital in Exeter.

Q You were formally employed by the Salisbury NHS Trust at Salisbury District Hospital?
A That is correct.

Q What was the post there?
A The same.

Q Dr Holme, I want to ask you about your involvement with a patient whom we are calling Patient A, I appreciate that may bear no relation to his actual name or the letters of it. In respect to this child we have a bundle of medical records which I would like to refer you to. Just to explain for the point of view of the Committee, we have not copied these records in full yet because we were not entirely sure how many we needed to refer to, if you will bear with us in terms of inviting Dr Home to have a look at relevant parts of the records, then we can copy those as necessary. The alternative is to copy 139 pages of which we will be referring to only a small number. If the Committee is happy with that?

THE CHAIRMAN: Mr Morris?

MR MORRIS: Sir, I have seen the bundle, thank you very much. My solicitor is busy copying some of the pages at the very moment, which I will be using in cross-examination.

D5/48
THE CHAIRMAN: It would be necessary to copy all 130 odd pages?

MR PEARCE: No, it would not. To be honest, we could pick them out. The alternative course is to pick them out and to photocopy them now. At least you get them all in one go.

MR MORRIS: Perhaps we might combine our two photocopying efforts to one bundle.

THE CHAIRMAN: I think that would be a good idea. We will adjourn again and you will let us know when you are ready.

MR PEARCE: Yes.

THE CHAIRMAN: Dr Holme, we are going to have a short adjournment, you are under oath so you should not be discussing your evidence with anyone during this break.

The Committee adjourned for a short time

MR PEARCE: I am so, sir, that that took longer than we anticipated. It was a little more complex to fit all the pages together and get good copies of everything, but we are now ready to go. Can I introduce, as I think C12, a new exhibit which is extracts from the medical records of Patient A.

Copies of the document were distributed

THE CHAIRMAN: Thank you.

MR PEARCE: And the typed page numbers reflect the fact that these are extracts from a fully paginated bundle. Some have had to be written in because of the way the photocopying has worked, but that explains the numbers:

Q (To the Witness) Dr Holme, it is apparent I think from the first page of C12, which is numbered 30 at the bottom, that Patient A is a boy, date of birth 12 November 1987 we see?
A Yes.

G Q I think your involvement started if we look through to the page that is numbered 104, and there is a letter to you from on the next page we can see it is Dr Margaret Vereker, is it, Consultant Child and Adolescent Psychiatrist?
A Yes.

Q Dated 20 March 1995. She sets out something of the background and just over halfway down Page 104:

"Patient A had also had significant behavioural and emotional
difficulties with an abnormal pattern of attachment. However, there has been considerable improvement since his adoption two years ago.

Mr and Mrs A have asked me to specifically assess his level of attention and activity and to consider the use of stimulant medication (Ritalin).

Dr Vereker makes some comments about that and then she says this in the next paragraph:

"I have a number of reservations about the use of Ritalin, as it is found to be less useful where there is a significant amount of emotional disturbance, contributing to the picture".

And then over on the next page:

"I have agreed with Mr and Mrs A that I would consider a trial of Ritalin ... I have undertaken an assessment of base lines of behaviour and activity levels and...",

and then:

"Mr and Mrs A have concerns about Patient A's physical health and would value your opinion about his growth and development".

Is this letter how you first became involved in Patient A's care?

A. That is correct.

Q. And I think you responded by a letter typed on 24 April 1995, following a clinic on 20 April 1995, and that letter is Pages 102 to 103 in this bundle. You set out various features of your examination of Patient A and you conclude, the top of Page 103:

"I think he is fit for regular Ritalin Therapy but he would need regular checks on height, weight and blood pressure, presumably these could be arranged through his own General Practitioners Surgery".

And I think following that referral is it right that in fact Patient A was started on Ritalin - methylphenidate?

A. I believe so by Dr Vereker's team, yes.

Q. By Dr Vereker's team. Now, could I ask you to look at Page 95 and 96 in this bundle?

A. Yes.

Q. A letter dated 3 May 1996, which we see on Page 96 is signed by Dr Cosgrove. It is clear by now that Dr Parry, who I think we can probably reasonably take to be A's
General Practitioner, has made a referral to Dr Cosgrove in respect of A's condition and that Dr Cosgrove has diagnosed ADHD. And does Dr Cosgrove then set out, at the bottom of Page 95 and on to Page 96, a proposed prescription of Ritalin?
A       Yes.

Q       Could I ask you about the middle of Page 96? It there says:

        "I understand from Mrs A that Dr Vereker is concerned about his weight which although it has not dropped has not increased either. However, I have been told that his weight is on the 50th centile, and this does give us a lot of leeway in raising the dose of Ritalin".

Could I ask you then to look at Page 93?
A       Yes.

Q       Is this a letter from you to another General Practitioner at the same surgery in Whiteparish, Salisbury, dated 22 May 1996?
A       Yes, it is.

Q       And do we there see in the second paragraph a reference to A's "... head circumference at 55.2 cms is over the 97th centile for his age, whereas his height and weight are both between the 2nd and 9th centiles"?
A       That is correct. That is what I have written, yes.

Q       And is that how you found Patient A at that time?
A       Yes.

Q       What then do you make of Dr Cosgrove's reference to him understanding, or his having been told, that A's weight is on the 50th centile on or around 3 May 1996?
A       Well, I was not quite sure where he had got that information. Whether he had actually weighed this patient in his own clinic or not, it would appear not. I think he must have taken word of mouth information from somebody.

Q       I see. Now that letter from Dr Cosgrove that I have just referred to, Pages 95 to 96, is copied to you and to Dr Vereker. You will then I think have become aware, and indeed you refer on Page 93, to Dr Cosgrove's involvement?
A       Yes.

Q       You also say in the last major paragraph on Page 93:

        "Margaret Vereker joined me for a major part of the consultation and at the end we agreed that the management of the Ritalin dosage would be left to Dr Cosgrove at The Bristol Priority Clinic. Input on behavioural and cognitive training would remain with Mrs Corrigan, the Child Care Specialist"?

A       Yes.
Q And what, if any, involvement were you to have in the management or monitoring of Patient A having regard to the prescription of Ritalin?
A What I would normally do on this occasion is see the patient roughly every six months just to ensure that appropriate services were being received and that the child was maintaining good general health. And if I had a need to communicate with say education in a statutory role because of any advice in terms of special educational needs then I could do that and, if I had anything to share with Social Services, I could do that. We did agree that the management of the Ritalin dosage would be left to Dr Cosgrove.

Q And what about the monitoring of Ritalin?
A Well that, again, would have been -- I guess would have been the GP's responsibility in terms of checking weight, height and blood pressure, etc.

Q Right.
A But I am not sure if any clear arrangement was made between Dr Cosgrove and the GP. You know, normally in practice in the NHS we would have a shared guidelines agreement with GPs which we would both sign - both parties would sign. So, I do not know if that happened.

Q Right. But you did not take responsibility for that monitoring?
A No, no.

Q And you are not clear whether the GP did, or not?
A No, I think that is an unclear area.

Q Right, yes. Now could I ask you, please, to have a look at Page 74 in the bundle. This is a letter dated 10 July 1996 from Dr Cosgrove to Dr Parry, General Practitioner:

"Dear Dr Parry,

Since I wrote to you last, I have had three telephone appointments with Mrs A regarding A. I have taken the Ritalin dosage up from 10 mg om ...",

which I understand means in the morning?
A Yes.

Q "... 10 mg lunchtime; 5 mg 3 pm; 5 mg 7 pm to 15 mg om; 15 mg 12:15 pm; 10 mg 3 pm; 7.5 mg 7 pm".

Just to do our maths there for a moment, that is an increase from I think 30 mg per day to 47-and-a-half, if my maths is accurate, mg per day. "His appetite ..." -- Oh, I am sorry. Carrying on reading from there:

"He is less hyperactive except in the evenings after 7 pm. School are very pleased with his behaviour, concentration and motivation since the last dosage increase. They have noticed his self-esteem
has improved. He is less of a management problem at home except in the mornings before the first dosage and in the evenings.

His appetite has dropped and his mother does not think that he is eating sufficient through the week. She thinks he is thinner and intends to ...",

well I had not noticed that I could not read that word.

THE CHAIRMAN: I think it is "weigh".

MR PEARCE: Sir, would you just give me a second because I had not noticed that that was not clear. Yes, "weigh". It is clearly "weigh" in the original - w-e-i-g-h:

"... him. Also his asleep time has not improved being between 10:30 and 11:30 p.m. He has been having some headaches recently which might be due to insufficient sleep. (His mother is to get his eyes tested). In view of his poor appetite and wakefulness, I have decided to add a low dose Risperidone to his Ritalin. I have asked his mother to give him 0.5 mg om and 0.5 mg 3 p.m., and I will have a telephone appointment with her in about ten days after he starts the Risperidone".

So, did you understand that in July 1996 Patient A was started with a dose of risperidone?

A    Well, that letter was not copied to me. I saw this patient -- well I am not entirely sure when I had last seen him, but presumably I had last seen him in the clinic appointment which you have previously referred to.

Q    Yes.

A    So, the letter was not copied to me and so, unless there was a telephone call which is not recorded, then ...

Q    Right. Well, let me deal with it another way. If I ask you to look at what I think will be the next clinic appointment - it is Page 88, I think, in this bundle -- that appears to be a letter from you to the General Practitioner Clinic on 13 November 1996?

A    Yes.

Q    "Patient A is making good progress and his attention is at a level at which he can function. He is able to control ..." (presumably his) "... impulsivity within certain limits and can concentrate unaided for up to ten minutes. His blood pressure today was 100/70 and his growth satisfactory with his weight at 23.7 kgs being on the 9th centile and his height 124 cms being between the 2nd and the 9th. His drug treatment at the moment consists of a total of 60 mg of Ritalin a day, plus 1/2 tablet bd of Risperidone"?
A

Yes, I think that must have been the first time I knew about the addition of risperidone.

Q

I understand. I understand. If I may then take you on from there, you were seeing Patient A, what, about every six months?

A

Yes.

Q

If I can ask you to look, please, at Page 128 in the bundle, is this your record?

A

Yes, it is.

Q

All right. What was your understanding of the dosage of risperidone as at 14 May of -- I think this is 14 May 1998, a clinic on that day is it?

A

It looks as if it had gone up to 1 mg twice daily, whereas previously it had been half a mg.

Q

Yes. And in terms of the Ritalin dosage, what does that appear to be at this stage?

A

I have written down that it was 30 mgs at 7 a.m., 30 at 11, 20 at 14:00 and 20 at 17:00 making a total of 100 mgs a day.

Q

Could I ask you, please, just to look at Page 73 for a moment. I appreciate this is not your document and you may not have seen it at the time, but I just want to ask your understanding of it if I may. It appears to be a note from Dr Cosgrove, dated 23 March, and so a couple of months before that attendance. Looking there at what is said in respect of Ritalin, does it appear to be indicating that it is 30 mgs at 7:30 a.m. and 10:30 a.m., 20 mgs at 1:30 p.m. and at 4:30 p.m. and 10 mgs at 7:30 p.m., or am I misreading it?

A

Yes, I think that is correct.

Q

All right. And again I will be corrected on my maths if I am wrong, but that appears to be 110 mgs administered there?

A

Yes.

Q

But your understanding was 100 mgs as you have recorded?

A

Yes.

Q

Could I ask you then, please, to turn to Page 129 in this bundle. Again, is this your note of a clinic this time on 18 November of 1998?

A

It is.

Q

And what, if anything, did you understand about clonidine at this stage?

A

I understood that Dr Cosgrove had suggested a trial of a third medication, clonidine, but I did not have details of the dosage, and that that had been instituted fairly recently, I think, to that date.

Q

Might I then turn to Page 77 in the bundle. The numbers at least in my copy are difficult to read, but the one that immediately follows Page 76 in spite of all the gaps in this. It is a letter I think from Dr Holme, dated: Letter typed 26 May 1999 and clinic 20 May 1999. Do you see that, Dr Holme?

A

Yes.
"Patient A is now taking extremely high doses of Methylphenidate, 30 mgs at 7 am, 30 mgs at 11 am, 30 mgs at 14.00 and 30 mgs at 17.00. He then takes 10 mg at bedtime. In addition he is on Risperidone 1 mg twice daily and Clonidine at a dose which I assume is 100 ...",

and is that microgrammes "... at night"?
A  Yes.

Q  And just doing our maths there, pausing for a moment, that totals I think 130 mgs of methylphenidate per day?
A  Yes, yes.

Q  A little further down if I may, the fourth paragraph:

"Weight and height today continue on the 9th centile, A's weight was 29.7 kgs which is up slightly from last time. I noted a baseline tachycardia of 120, blood pressure 120/80, mother told that he had just had his Ritalin dosage".

Pausing there for a moment, could you explain for those who do not understand what a baseline tachycardia of 120 means?
A  Well, effectively it is his resting pulse.

Q  Right. And is that high, normal or what?
A  Yes, that is high for a twelve year old.

Q  "I am arranging for a routine full blood count and test of liver function. We need to keep a very close eye on Patient A with these extremely high doses of Ritalin".

What was your understanding of the monitoring that Dr Cosgrove was carrying out?
A  I understood it to be telephone monitoring by contact with the patient's mother.

Q  And where did you gain that understanding from?
A  From the mother's description.

Q  Following that clinic and the references made in that letter, did you have concerns about Patient A's medication?
A  I had concerns because we were now well above the upper limit that was commonly regarded as safe. The BNF refers to an upper limit of 60 mgs a day, and in a twelve year old boy we were above twice that limit on a combination of three drugs.

Q  Did you have any concerns about the combination of drugs?
A The use of risperidone I think at that time was not common practice in treating ADHD. It has become slightly more common recently. It is an atypical antipsychotic drug which in general is safe, but it can lead to side effects like bowel disturbance, abdominal pain and what is called a tardive dyskinesia. It is a muscle spasm, really, which would be unusual at the dosages that were being used. It is normally only used I think in circumstances where the behaviour is causing considerable concern and where there is a strong suspicion or at least a strong element of aggression. It is my understanding from Dr Cosgrove's practice that it seemed to be added as a sort of add-on extra to counterbalance the appetite suppressant effect of methylphenidate. And so you are treating a child with methylphenidate, where you get appetite suppressant, and so you are then adding some risperidone which makes you gain a bit of weight. So, you are using one drug to counteract the effect of another.

C Clonidine has got a long established role in ADHD and it is generally safe if monitored effectively, and the combination of methylphenidate with clonidine is a well-established combination, but there have been anecdotal reports in the Medical Press from the States particularly, I think, of sudden death in patients taking that combination and there does need to be close monitoring of pulse and blood pressure.

Q So as a result of your concerns did you make contact with Dr Cosgrove?
A I did, yes.

Q If we have a look at pages 68 and 69, there is a letter from Dr Cosgrove to you dated 3 July 1999. I think from the documents I have seen, it is not actually apparent how this letter comes about, if you like - how it comes about that Dr Cosgrove was writing to you then. Do you recall why that was?
A I think I wrote to him and expressed my concerns, if I remember it correctly.

Q In any event, Dr Cosgrove writes to you in these terms:

“I had the opportunity of meeting A with his mother on 30 June in Bristol. A looked well and alert. His appetite is very good, his mother reports, as a result of the Risperidone. He is growing in height and his weight is satisfactory. He is getting to bed at about 8.00 p.m., asleep by 10.00 p.m. and wakes at 7.00 a.m. His mother says that he is sleeping very much better on the Clonidine 0.1 mg; he is calm from 8.00 p.m. onwards.

I took his BP”

G - blood pressure, I think -

“…and his pulse rate on four separate occasions - two at the beginning of the session and two some 20 minutes later. The first two pulse rates were 113 and 120 per minute and the second two were 111 and 116 per minute. These figures clearly corroborate the 120/minute that you obtained and they would not be due to excitement or
anxiety as we considered on the phone.”

If we can just pause there for a moment, does it appear that you had a telephone conversation with Dr Cosgrove at some stage?
A I must have done, I think, yes.

Q “I asked his mother to try taking his pulse and it would appear that she does not find this too easy, so that her previous readings of 60 and always less than 100 are unreliable. A’s BP was 114/75.

I think that we have to assume that the methylphenidate presumably through its noradrenergic component…”

A Noradrenergic, yes.

Q “Noradrenergic component is responsible for this tachycardia and I told Mrs A that I did not feel that it could be ignored. This, however, leads to problems because we know that his behaviour deteriorated markedly when the Ritalin is reduced.

Nevertheless I have asked her to reduce the Ritalin to 20 mg 7.30 am, 25 mg 11.00 am, 30 mg 2.00 pm, 25 mg 5.00 pm of about 20 mg in the day.”

Now just pausing there for a moment with the maths, it is not entirely clear to me - it may be clear to others but it is not clear to me - what that sentence means. If it means that the reduction is to a total of the 20, 25, 30 and 25, that would indicate, as I understand it, a reduction to 100 mg?
A Yes.

Q Others may read it differently but it may be being stressed that that is a reduction of about 20 mg in a day, which might suggest that it was previously 120. You have made a record of 130 mg in any event.

“If there is no significant reduction in pulse rate but the behaviour worsens, then I have discussed with Mrs A using a low dose beta blocker, such as a non-cardioselective propranolol. Using 10 mg doses at 10 mg dose increases where necessary would be a reasonable step forward in reducing his pulse rate without losing the immense benefit of the Ritalin. As we discussed on the phone, the school appealed to Mrs A to increase the Ritalin dosage once more when she reduced it for a while. So we are in a little bit of a cleft stick here.

A’s godmother is a nursing sister who, together with Mrs
A, will monitor his pulse rate. For further corroboration, I have suggested that they get their pulse rate readings checked at the surgery using a sphyg.”

What is a sphyg?
A A Sphygmomanometer. It measures blood pressure.

“I have used propranolol with Ritalin in children with good effect and would have no problem in providing a private prescription to slow his heart rate to a reasonable level should this be necessary.”

Was Patient A’s care subsequently transferred to a colleague, a psychiatry colleague in another Trust for an overview of his treatment plan?
A It was at some point in that year, yes, because I had a telephone conversation with the child psychiatrist in Southampton.

MR PEARCE: I am obliged. Thank you very much. If you wait there Mr Morris on behalf of Dr Cosgrove will have some questions.

Cross-examined by MR MORRIS:

Q Dr Holmes, can I take you back to May 1996?
A For the record, my name has not got an ‘S’ on it.

Q I do apologise, Dr Holme. May 1996, 3 May we have Dr Cosgrove writing to A’s GP and we have that at 95/96. That letter of his, which sets out his diagnosis of ADHD and his treatment that he was going to start the patient on, is copied both to yourself, Dr Vereker and Mrs Corrigan, the childcare specialist?
A That is correct.

Q You then see, if I am right, the patient ten days later on 13 May in a clinic. I think your clinic notes we see at page 125 and the letter you write subsequent to that clinic at pages 82 and 83. Just looking at 125, please, am I right in thinking that we have got an entry 13 May 1996?
A Yes.

Q New letter, seen with Dr Margaret Vereker. Is that your writing?
A It is, yes.

Q Can you just run us through the entries you have made there, please, because obviously it is easiest coming from you?
A This consultation was in response to a new referral. I noted mother’s concerns about the patient’s physical status, the size of his head, certain unusual facial features, his rather loose-limbed gait, learning difficulties and his attention deficit problems for which he was under Dr Cosgrove. Physical examination was generally satisfactory.

Q When you did your examination, I think you found that he was less inattentive
than before. Is that right?
A Yes. That is presumably compared to when I had seen him once before in April of that year - April of the year before, wasn’t it? 1995.

Q Are we right in thinking that by that time Patient A was on the Ritalin prescription as advised by Dr Cosgrove in his letter of 3 May?
A Yes, must have been.

Q Then I think you noted his height and weight. Is that right? Or was that nurse noting that, on the left-hand side?
A Yes, that is correct.

Q “Weight 21.5, height 121 cm. 2-9” - I anticipate that is the centile range?
A Yes, that is correct, yes.

Q It appears to be in different writing. Is that your writing?
A That is my writing. It is probably in different writing because I suspect what I did was looked at the growth chart at the end of the clinic and perhaps used a different pen.

Q You were happy to see him again in six months’ time?
A That is correct, yes.

Q You said in answer to my learned friend that you did not take responsibility for monitoring him in relation to medication he was receiving but, as a matter of fact, did you not actually monitor him over the months and years as far as his condition of ADHD and the effect that the medication was having on that?
A I did but I guess in perhaps a rather second-hand way because I was not directly responsible for the prescribing and therefore I would not have monitored him, say, on a monthly or six weekly basis but I would have certainly checked his blood pressure, pulse and weight whenever I saw him. I could not, because of the demands on clinic time, see him as often as perhaps would have been best practice, simply because of lack of clinic availability.

Q Right but when you did see him you certainly addressed the issue of the condition, the medication he was receiving and what effect it appeared to be having on the patient?
A Yes, that was my duty of care, was it not, on the occasions I saw him.

Q All right. I would just like quickly to run through those, if I could. As a result of that clinic I think you wrote to the GP, Dr Gotham on 22 May. I think we see that at page 93. I may have said 83 earlier but I meant 93, where I think you set out your findings from the clinic. Is that right?
A Yes.

Q You copy that letter to, amongst others, Dr Cosgrove?
A That is correct.

Q I wonder if you could help us with this. It is not a letter that you wrote but I do not know whether you can assist with this. On 12 July 1996 at page 89, Dr Vereker wrote to Patient A’s mother:
“Thank you for your kind letter of 11 June 1996. I am sorry if it appears that there was bad feeling about A’s transfer to the care of Dr Cosgrove. As we discussed, I am very happy for A to be seen by Dr Cosgrove and I was pleased to hear that he is doing well.”

Can you help us as to what certainly from the point of view of the parents appeared to be some bad feeling on the part of Dr Vereker about the transfer?

A You are asking me to go back several years and there is no documentation of what the circumstances were. I am not sure that I can help you. Dr Vereker may have felt that she had very good reason for prescribing Ritalin at a certain level and then it could be that she was upset that a GP had made a referral to a private practitioner perhaps without referral to her. I am not entirely sure. That could have been the issue.

Q Then you see him again about six months later. If you look at page 125, 13 November 1996. This presumably would have been with him and his mother or father or both?

A Yes. It was usually the mother.

Q You set out there the dosages that he was on, time that he was receiving them, functioning well. Help us with your writing thereafter. “Attention at a level at which he can function”?

A Yes.

Q “Can control impulsivity within limits. Concentrates unaided ten minutes. Had a good holiday.” Then you go on on page 126, blood pressure 100/70 growth, tick?

A Yes, inasmuch as his weight and height were maintained in the same centile channels. They are on the left-hand column, 23.7, ninth centile and height the second to ninth.

Q Then you write a letter incorporating those findings at page 88 to the general practitioner with a copy to Dr Cosgrove and the main and perhaps only problem that you were addressing in the clinic here would appear to be the problem of hyperkinetic disorder?

A Yes.

Q In relation to monitoring that disorder and its medication and treatment, I think you make reference to specific hospital - Maudsley Hospital - guidelines?

A That is correct, yes.

Q Were those guidelines specifically for the management of medication treatment of ADHD?

A Yes.

Q Six months later, 15 May 1997, page 126, you are seeing him again, I think. Is that right?

A That is correct.
You established the medication he is on, that there is a telephone check with Dr Cosgrove every two months and then you have, am I right in thinking you have a sort of checklist - concentration and you comment on that?
A Yes. I just said the dose impact of an individual dose is apparent. In other words, I usually asked the parent or carer, “Can you see an effect from the medication within a certain time?” I record their response.

Then you ask about and enquire about impulsivity, “Less marked, verbal control better, may take time out when he can’t cope. Levels of activity still high.” You ask about his sleeping and check on his appetite?
A That is correct.

Again, I think you are checking that his height and weight remain within the centiles at which they were at the start of medication?
A That is correct, yes.

Then you write again on 19 May, we see that at pages 86 and 87, incorporating your findings and a copy to Dr Cosgrove and specifically in relation to weight and height you comment that they are both progressing between the second and ninth centiles as before and you note his blood pressure. If we can move on, then, please, to November 1997 at page 127. I think he has changed schools at this time, has he not?
A Yes, I think he must have done.

On the pro forma height/weight box, again it appears to be between the second and ninth centiles?
A That is correct, yes.

You go through your checklist in relation to concentration, impulsivity and restlessness. Can you help us with what you have written there?
A It looks as if those were written that the school were having to work on his concentration and try and support him. He was best, he was concentrating best mid-way between tablet dosages, so in other words at a time when the tablets were well and truly in his system but at other times it looks as if his concentration wavered.

Impulsivity?
A Likewise, variable and emotional levels up and down. We know that children can get more emotional on these higher doses of methylphenidate.

The restlessness?
A It appeared to be dose-dependent. Again, irritability can be a sign, in fact, of methylphenidate.

What were you reporting there? That the restless increased depending on the dose or that the restlessness decreased?
A I cannot remember, I am afraid. I cannot remember.

Look at your letter following that clinic, page 84 and 85, I think a little more information from you there, A's mother is awaiting reports on how well he is doing from
the point of view of concentration and impulsivity at school. She points out he does appear to be at his best at midway point between dosages:

“The present dose of Ritalin is two or three tablets in the morning, 3 at midday, two at 3.30, 1 in the early evening. In addition, he takes Risperidone 0.5 mg in the morning, 1 mg in the evening, he does appear to be generally quieter in the evenings nowadays

...height and weight progressing well between second to ninth centiles.”

Blood pressure 70. 14 May 1998 you see him again, page 128. Height and weight remain within second to ninth centiles.

And the dosage that you note there is one hundred, is that correct?
A Yes, that is correct.

Q Risperidone, one milligram, twice daily. Is that a comment related to the Ritalin of three hour gap instead of four?
A Yes, between the dosages, yes.

Q Underneath that you have written:

“Improved impulse control /social”?
A Presumably social responsiveness.

Q And learning:

“Sleeping is difficult sometimes.
Confident in approaching adults.”

14 May. 20 May you are writing again to the GP, 82, 83 with a copy to Dr Cosgrove confirming that growth is continuing between the second and ninth centiles. Full blood count and liver function tests ordered last time, both normal. You are seeing him again on 18 November, page 129. Height and weight, what are you writing next to that on this occasion?
A I think mum generally commented that there had been ups and downs over the past few months.

Q I meant in relation to the height and weight?
A The weight was just above ninth centile, so it was in the ninth to twenty-fifth centile bracket and the height was 90.

Q So it has moved up somewhat in terms of centile?
A Yes, but, I mean, these slight variations are not statistically significant. You have got to cross a couple of centiles to be significant.

Q Page 80, you are writing again to GP together with Dr Cosgrove, confirming that his growth is satisfactory, blood pressure well maintained:
“Understand he is on Clonidine at weekends”,
not sure of the effect of that of that yet.

Then 20 may---
A Could I point out that in that letter I did highlight the increased amount of
aggression he was showing and this could well have been a side effect from the
methylphenidate at that dosage.
I pointed out that he was getting wound up very readily and was showing physical
aggression.

Q Did you think at the time that that might be a side effect of the---
A Well, it was that level of dosage, I was concerned about it. I was beginning to get
concerned.

Q You have not noted that in your letter to the GP or Dr Cosgrove?
A I said:

“…the time has come to re-open negotiations with Social Services for
some respite care.”

Q How did that comment suggest to anyone that you were concerned that this could
be the side effect of the medication?
A Well, it was difficult to be certain. I mean, at that time I did not have enough
evidence to be certain about it. I knew because of this boy’s complicated background and
many social concerns, I wondered if it was primarily a social problem but it could have
been a bit of one and a bit of the other.

Q If you had had some concern that it might be a bit of one and a bit of the other,
would you not only have been suggesting a possibility of respite care but getting in touch
with Dr Cosgrove to suggest that?
A Well, I copied my letter to him. I never used to get a letter back. So Dr Cosgrove
would have noted my comments.

Q On 20 May 1999 you see patient A again at page 130, height and weight in the
ninth centile. Is that correct?
A Yes.

Q Then you note Dr Cosgrove had suggested increasing Clonidine in the evening,
you note the tachycardia:

“Behaviour always on edge with sister”?
A Yes.

Q Then you set out the Ritalin prescription of 110, Risperidone and clonidine?
A Ritalin was 130.

Q I beg your pardon, 130, and you write on page 77 on 26 May to the General
Practitioner with a copy to Dr Cosgrove:
“A is now taking extremely high doses of methylphenidate.”

Do you have that page?
A Yes.

Q I think as a result of those concerns you, as you have said, certainly spoke with Dr Cosgrove on the phone?
A Yes.

Q But you probably wrote to him, you think?
A I think I did.

Q Do you have a copy of that letter now?
A No, I do not, no.

Q Did you accept that at the time your view of this child was that he was a challenging and complex child with the severe attentional difficulties?
A He came from a very disturbed background with, from my recollection, abuse in the early years, and probably a failed attachment. All of these events would have coloured his personality and his emotional development. To what extent, I mean, I think I agreed that he did had ADHD, but it had to be considered against the complex of other problems and also his management was made difficult by the fact that we had very little response from Social Services in terms of support.

Q If we can move on to October 1999, page 131, I think this is probably not your writing?
A No.

Q Then we will find out whose writing that was, but if you look at page 58 for a letter, no, sorry, this is a letter from the General Practitioner Dr Parry. It is clear that Dr Parry was trying to get a second opinion and that patient’s mother is keen to see Dr Eyre at Swindon, a paediatric psychiatrist. I will take you to 20 December 1999, it appears that Dr Eyre saw the patient page 50 to 51. Page 51 he talks of three issues affecting, the child, first is his early abuse prior to being placed with his parents. It is clear that he was adopted?
A Yes.

Q Second issue is learning difficulties. Third issue, that of his medication regime:

“It does seem that apart from tachycardia A has been well. In theory the tachycardia could relate to the stimulant medication Ritalin or to the hypotensive effects of his Clonidine. It is however common practice amongst specialists to prescribe Ritalin and clonidine together. I am however not familiar in my own practice of the triple combination which A is taking. I am informed by the mother that Dr Cosgrove suggested to use a beta blocker in order to combat the tachycardia, thus resulting in a regime of four medications.
Then various options are set out. One option is to ask for an opinion from a paediatric cardiologist. The second one is to start again, seek an expert opinion from either Professor Taylor or perhaps Professor Hill.

I think the former option was pursued, if we can go to page 49, where unfortunately it is a rather badly copied letter from the consultant paediatric cardiologist, who talks about the ECG, a copy of which he was sent which was taken on 9 December 1999:

“I understand A has significant problems and it is therefore important for him to be on Clonidin, Risperdone and Ritalin. What I don’t have a feel for is what extent is he tachycardic and what extent does that affect him. The ECG that you had kindly sent shows a low atrial rhythm at a rate of 95 bpm. This is a physiological variation where the atrial beat is initiated from the lower part of the right atrium and this is often exists with periods of sinus rhythm where the atrial beat arises from the sinus node. A heart rate of 95 is slightly faster than average for a baseline heart rate of a sixteen year old but is not unusual to record such heart rates during a consultation.

Symptomatic sinus or low atrial tachycardia would not warrant pharmacological therapy in paediatric practice. It is possible these medications might cause a slight rise in baseline hear rate but I think it is most unlikely that this would lead to any symptoms. I would not normally advise any further action on the basis of the ECG that I have seen but if there is a feeling that he is unduly tachycardic a 24 hour tape me be helpful in documenting this.”

So he, on the basis of the ECG available to him, did not appear to be too concerned about the condition of the patient?

A I am not sure this is a major issue. Is this the major issue?

Q Well, am I right? Is that a fair summary?
A It may well be. This is fresh to me, but I am not entirely sure that this is the major issue.

Q I think by that time you had moved off, had you, to?
A To Exeter, yes.

Q So summarising it, again, on a six monthly basis you were certainly monitoring the medication?
A I was monitoring when I saw him. I did not give a guarantee to monitor him continuously in between times.

MR MORRIS: Thank you very much.

MR PEARCE: No questions in re-examination, sir.

THE CHAIRMAN: There may be some questions from members of the panel.
DR STANLEY: Back to page 130, may I ask about your starred comment at the bottom of the page there because I am not sure what that means?

A I, at this stage, was seriously concerned about the, I suppose the principles and the ethics of -- for which we really did not, had not received clear guidance on where practitioners stand in relation to private practitioners suggesting/recommending a course of treatment to a General Practitioner with the patient also being seen by an NHS hospital consultant. I was not at all clear where responsibility lay for the consequences of prescribing. There did not appear to be a shared agreement. There was not a documented shared agreement to my knowledge between Dr Cosgrove and the General Practitioner whereby -- at least the only agreement seemed to be that Dr Cosgrove would send a copy of his private prescription and expect the GP to dole them out on the NHS subsequently, so there was an initial private prescription and then an NHS one from the General Practitioner.

Now, where does the GP stand in relation to risk - clinical risk - when the consultant in private practice was recommending the drug at twice or over twice the upper limit of the normal recommended dose, and was engaging in serious polypharmacy and, indeed, at one point recommending four drugs; two of which were going to be counteracting the effects of the first?

And so I had serious concerns about where we stood ethically in this situation and I think we needed a clear direction as to which way we were going, and I was looking to the GP I guess to give a bit of a lead here because the GP was in prime responsibility, I suppose, of the child. Would it not be best if this child was entirely within the NHS and the child was actually managed by a team of people working together, who wrote letters to each other and corresponding? I do not recall, except perhaps on one or two occasions, ever receiving a letter from Dr Cosgrove telling me what the alteration in dosage was.

Q Thank you. Now, I am not sure what I interpreted here as "COH"?

A That is any initials.

Q So, it is "Please speak to COH", and that is you?

A That is me, yes.

Q Right. So, I am sorry, but whose writing is it?

A That is my writing in case anybody else had picked up the notes and was going to deal with a situation that they would need to refer to me.

DR STANLEY: Yes, I see. Thank you.

THE CHAIRMAN: (To the Witness) Yes, the questions I want to put are along a similar line. As I understand it, the initial prescription of Ritalin was made by Dr Vereker?

A Yes, that is correct, on NHS.

Q Right.

A Well, within the documented guidelines.
Q  And this was after you had undertaken a physical assessment of Patient A?
A  Yes, she wanted my opinion as to the physical state of the child.

Q  And that prescription having been started by Dr Vereker, am I correct in thinking that you would have an ongoing monitoring role at approximately six monthly intervals?
A  That is what I suggested I would do, yes.

B  Q  Yes.
A  Yes, I was very happy to work in concert with Dr Vereker because I saw her on a regular basis and we worked in the same hospital.

Q  Yes. You also suggested that there would be certain duties put on the General Practitioner to monitor between the six month assessments you did?
A  Yes.

C  Q  Is that correct?
A  That is correct.

Q  Were these done?
A  I would hope so. I mean, certainly for example in Exeter we have written guidelines and shared -- you know, each party signs that they will do their bit. I do not recall that we had similar shared guidelines in Salisbury in those days, but the understanding I think on the part of the GP would be that the weight and the blood pressure should be monitored.

Q  Would the referral back from the GP to you be on the basis of abnormality, or routine normal assessments?
A  I am sorry, I did not catch you?

E  Q  Yes. If the assessments done by the GP were satisfactory, would you expect to hear that they were satisfactory?
A  Not necessarily, no. It would have been -- no. I mean it would have been nice to hear, but I would have certainly expected to hear if they were abnormal.

F  Q  But you would expect to hear if they were abnormal?
A  Yes.

Q  Right. The psychiatric oversight of this patient having moved from Dr Vereker to Dr Cosgrove, am I correct in saying that you continued to monitor in exactly the same way as you would have monitored if the patient was still under the care of Dr Vereker?
A  Yes, that is correct. That is correct.

G  Q  And you ---
A  But ---

Q  I am sorry.
A  Sorry, go on.

H  Q  And you kept Dr Cosgrove informed in relation to copies of letters, etc.?
Yes, it was my routine practice to copy my clinic letter to him whenever I saw the patient.

Yes. But the return the other way was not as prolific?

No.

The Chairman: Thank you very much.

Mr Pearce?

No, thank you.

The Chairman: Well, that concludes the evidence. You are now free to go. I thank you very much for attending to assist us.

(The witness withdrew)

The Chairman: The Panel had a reasonable break, but I am conscious of the fact that the Legal Teams did not have a break. Are you wanting a break before we go on for a bit more?

Not personally, sir. Effectively I did have a break whilst the documents were photocopied.

Yes, all right.

Dr Al Shabnder, please.

Dr Kais Mohamer Khalid Al Shabnder. Sworn

Examined by Mr Pearce:

Could you give the Committee your full name, please?

Kais Mohamer Khalid Al Shabnder.

Dr Al Shabnder, what is your current occupation please?

I am an Associate Psychiatrist.

And by whom are you employed?

By the Bromshire(sic) NHS in Wales.

All right. Were you in 1999 employed as an Associate Psychiatrist by Pembrokeshire and Derwen NHS Trust?

Yes.

Could I ask you, please, to look in one of the bundles of documents that is there. It is called C8. It is not one of the ones that you have brought in. It will be one of those to the right of you and it may have handwritten on it "C8", do you see that?

Yes.
Q Could I ask you, please, to look behind Tab 3? Do you see Tab 3?
A Yes.

Q And do you see a letter ---
A Yes.

Q --- dated 3 December 1999 on notepaper from the Bristol Priority Clinic?
A Yes.

Q And three pages on is it signed by Dr Cosgrove?
A Yes.

Q And do you see that on the third page it says, "cc Dr K R Shabnder", and there is reference to other parties there?
A Yes.

Q Do you see that?
A Yes.

Q Did you receive a copy of this letter ---
A Yes.

Q --- in or around December 1999?
A I did, yes.

Q Now, I want to ask you first of all a little bit about the examination to which this letter refers. Have you re-read this letter recently, Dr Al Shabnder?
A Yes, I know it.

Q And are you acquainted with its contents?
A Yes, yes.

Q The patient to whom it refers for purposes of anonymity we shall call Patient B in the course of this hearing, if we can. Do you recall having an appointment to see Patient B?
A Yes.

Q And do you recall much about that appointment now, or consultation?
A Yes, I do. I do remember, but I do not know what specifically you want me to remember?

Q No, no, that is all right. I am just asking in general terms do you recall it?
A I do remember it, yes.

Q Right, okay. And B, I think, was an adult patient?
A Yes.

Q According to this letter here, we see on Page 1 of Tab 3 that Dr Cosgrove speaks of Patient B having poor concentration, short attention span and distractability?
A

Yes.

Q Are those features of Patient B that you recall?
A He did say he have all these. On Mental State Examination he did have some, but not all. I do remember him saying that he have the following, 1, 2, 3, 4, 5. It is not a matter of me eliciting them one by one.

B

Q He said he had these symptoms?
A Yes. He came very determined that he has 1, 2, 3, 4, 5. he did name the diagnosis and he did ask for the treatment.

Q What diagnosis did he name?
A Attention Hyperactivity Syndrome.

C

Q And what treatment did he request?
A He requested stimulant, as far as I remember. Psycho-stimulant medications.

Q All right. Did you prescribe such medication?
A No, I did not.

D

Q Right. Now let me just, if I can, take you to the second page of this letter from Dr Cosgrove. I think it is clear -- you tell me if I am wrong, but I think it is clear that the person to whom he is referring as being the Psychiatrist whom the Patient B saw was indeed you?
A From the letter that is what I understand, yes.

Q Yes. Now dealing if I can with the allegations in turn, the paragraph the second from the end of Page 2 here begins as you will see:

"There is some importance in this ..." (that is to say in who it was)
"... since whoever Patient B actually saw, he found him to be rude and quite unhelpful".

First of all, were you rude in the course of this consultation?
A No, I was not.

Q Were you, in your judgment, unhelpful in the course of the consultation?
A No. If you put unhelpfulness, he asked me to prescribe this -- to give the diagnosis and prescribe the medication. I did not.

G

Q You did not do what he asked you to do? Give the diagnosis he asked and to give the prescription he asked for?
A But had I done this it would not be helpful.

Q Yes.
A That is what I am saying.

H

Q I understand. And carrying on in the same paragraph:
"Patient B describes him ..." (that is to say you)... as being a scruffily dressed man in his fifties or possibly his forties.

Were you scruffily dressed?
A It is very unlikely, to be honest with you. I mean, I do not see a reason why I would be scruffily dressed.

Q I take it you cannot recall what you were wearing then?
A I mean I do not dress like a TV star, but I do not -- nobody ever have said that I look scruffy. I do understand people come to see me wearing best they have and so I do try to wear reasonable good things.

Q Yes.
A I always wear a tie and I always wear ...

Q Yes.
A I do not know what -- I do remember this very well, it is in the letter, and I have been thinking about it.

Q Yes?
A I do not know where it has come from.

Q Right. It is suggested in this next sentence:

"The appointment got off to a bad start in that this doctor sped on ahead so that Patient B found himself at the top of some stairs with no one in sight and not having a clue as to where to go".

Do you recall that you did that in this consultation?
A There is a secretary at the beginning of the corridor. She tells the patient either to wait, or to come in along, and she either has done any of those two. I was not with him at the time, but I do not think that ever could happen because it is not in the interests of anybody for just leaving somebody there without -- I was not there, if you ask me, and so I do not know to be honest with you, but it is not likely. That is my conclusion here.

Q Did you rebuke him? The next sentence suggests that you rebuked this patient, saying that you had been waiting for him. However that may have come about, did you rebuke him saying that you had been waiting for him?
A I do not remember. It is unlikely again, but I do not honestly remember.

Q Now, in the next paragraph we see that reference is made to you asking Patient B to subtract seven from 100 and then seven from 93. It is not actually stated whether he was asked to continue repeatedly subtracting seven from the answer, but would you have done that?
A I might well have done that. This is part of the Mental State Examination. I remember him saying that his memory is not very well. This is one of his, you know, presenting complaints. You know, one of the many presenting things that he was saying. And one of the things I do is, you know, sometimes I might well ask that, but before I do
this I tell them, "Look, you know, I have to do this".

Q Yes?
A And we do it and I never had any problems doing it.

Q Okay. So, the answer is you may have done it?
A I might well have done it, yes.

Q And you do on occasions?
A Yes, yes.

Q Yes. At the top of the next page it is said that you said, "There's nothing I can do for you"?
A There is no way. You know, knowing the patient and knowing the circumstances, it is not for anybody's best interest to say that. This would be very stupid, you know? He came in to find out an answer and ask me specifically about something and, you know, you only alienate people by saying things like this.

Q It is suggested that you said that this patient may or may not have deficit syndrome?
A In the diagnosis I wrote that it is one of the differential diagnoses, but it will be very immature to diagnose him that at this point in time without at least doing some investigation and rolling out other possible things.

Q Can I be clear about what condition it is you are saying was one of the differential diagnoses here?
A Attention Deficit Hyperactivity Syndrome. This could be one of his differential diagnoses, you know, what he have, but to reach such if you like one of the big diagnoses in psychiatry because of the implication of treatment, then you need to rule out other psychopathology. And, to be honest with you, at that point of time my feeling is that to give that diagnosis is oversimplifying the whole case, yes? That is the feeling of the team as well when we discussed it afterwards.

Q It is suggested in this letter that you knew nothing about attention deficit hyperactivity disorder?
A No, that is wrong. This is one of the things that comes up in examinations at the Royal College of Psychiatrists. This is one of the articles. I would not call myself a world expert about it but it is not something that you do not ever know about. It is one of the things that one should know about but it is one of the things that you know that it is not one of the bread and butter illnesses that you rush into diagnosis and treatment immediately. This has consequences. This has serious medication afterwards. It needs follow-up. When you take a diagnosis like that you need to be reasonably firm, reasonably happy about it.

Q How often do you see children in consultation?
A I do not.

Q You are not a child psychiatrist?
A No. I know this is one of the domain of child psychiatrists and child
paediatricians but they do continue in adult life and it is one of the differential diagnoses in so many things. Even a personality disorder, which is bread and butter in psychiatry, you have to at least think of this.

Q Just to be clear on that specific point, I think it may be being suggested in this letter that you were saying that ADHD cannot be a diagnosis in an adult. It does not say it expressly but it might be read that way?
A It can. It can continue to adulthood.

Q It is suggested that you said that you wrongly said that Patient B was well-motivated. Do you remember what you identified in respect of this patient’s motivation?
A You see, what psychiatrists mean about motivation is that he is goal-oriented in what he do to satisfy his inner needs. That is what motivation means. If you take this patient, yes, he is. He has inner needs and he is pursuing them and that is what I mean by good motivation.

Q It is suggested that you were professionally incompetent, either in this consultation or more generally, but take it that it refers for the moment at least to this consultation. Do you agree with that?
A No. I do not agree. No, I do not agree.

Q You have indicated that you would not make a diagnosis, it would be wrong, immature, you say, to make a diagnosis at that stage. What if any further investigations might properly be made before a diagnosis was reached in that?
A Well, in psychiatry, you see, the investigation is to go and ask about the background. You ask relatives, you ask next of kin, you ask community psychiatric nurse to go and see the patient at home and report back. You have a general feeling of what is going on. You see, diagnosis means nothing without taking the background and the circumstances, so you have to put the background, who the patient is and that gives you a final diagnosis that puts everything into perspective.

Q I understand.
A You have to understand why and you certainly have to ask next of kin, you have to ask CPN, people to go to his home, you have to see him again and have a feeling of how this is developing as well. Seeing the patient once is a flash in time and to make such a huge diagnosis, in my opinion, you need to know more, you have to know more.

Q How did you respond to receipt of this letter, Dr AlShabnder?
A Normal. I think first you deny that it has happened, then you start to be angry and then you try to live with it.

Q This letter we know was sent to the general practitioner and copied to, I think it is Patient B’s parents. Did it come to your attention that the contents of the letter were known about more widely than those people?
A Aberystwyth is a very small place. It is not like Manchester here, or London. Everything with anybody is known to everybody everywhere. We have the outpatient clinic is above a day hospital where all patient comes in in day hospital and this letter has been found with other patients who sit in day hospital. I have seen people in the street who reminded me, “Yes, somebody says all this in the letter. What do you think?”
have people in Aberystwyth, I think like anywhere else, who are anti-psychiatry as that has been described and they used this as one of their main weapons, if you like. It has, I would say big, very big consequences because it is a small place, everybody knows everybody’s business and something like this will be known. It will be the talk of the moment for a long time, if you like. It is very bad for the psychiatry, for medicine, down there.

MR PEARCE: Thank you. I have no further questions at the moment but Mr Morris on behalf of Dr Cosgrove may have some questions.

Cross-examined by MR MORRIS:

Q Doctor, this letter that was sent to you and the only other recipients were the patient and his wife. Is that correct?
A It says here, “c.c.” to those people, yes.

Q The description of the consultation with you obviously did not come directly from Dr Cosgrove. It is Dr Cosgrove reporting, presumably, what your patient had said to him? Would that be fair?
A But I - can I add something to this one?

Q Yes, of course.
A Dr Cosgrove made a judgment from what the patient had said and he made his judgment very clear that I am medically negligent.

Q Right.
A And the whole service is bad and that is all judgment built on one person, if you like.

Q He was coming to a conclusion upon what he had been told by his patient?
A The conclusion he reached is very serious and anybody coming to that kind of conclusion should at least listen to the other side of the story.

Q But you would accept that, subject to your criticism he should have listened to the other side of the story, his conclusion was based on what he had been told by the patient, whether that conclusion is wrong or right?
A It seems to be. It seems to be.

Q You said in relation to the findings that Dr Cosgrove made when he saw the patient, together with his wife, in consultation, that some but not all of those findings were ones that you had elicited. Is that right?
A I am sorry, I missed it. Would you kindly repeat it?

Q Yes. I think Mr Pearce when asking you questions started off in relation, at the beginning of Dr Cosgrove’s letter to the GP and you, that the patient and the patient’s wife told him about poor concentration, short attention span and his distractability and I think you were asked whether or not you found or you recognised those as symptoms when you had seen him?
A Symptoms, yes. He volunteered saying that, yes, but they are not signs.
Q Help us as to what other, if we can look through the history that Dr Cosgrove took, please. We go on, “He finds reading very difficult and has to re-read each line two to three times before the contents sink in. His wife told me that he reads little and has never read a book in their 22 years of marriage.” What, if any, findings did you make in relation to his reading ability?

A Whether he can read or write, you mean? I know that in the interviews he could not shake my hand in the normal way, so he would not be able to hold a pen and write. I remember him making a fist and shaking my hand and saying that, “I could not open my fingers.”

Q When you saw him and he had this list of symptoms which he felt amounted to what he called a deficit syndrome, did you seek to investigate there and then to see whether or not you could confirm it or exclude it?

A Yes. That was the next step, yes.

Q The conclusion you wrote, did you exclude it?

A I wrote that it is certainly one of the differential diagnoses. It has to be considered but not considering and ruling out others would be serious, may be far more serious.

Q What steps did you put in place - you said that he needed further investigations. What steps did you put in place further to investigate?

A We had what we called DMT meeting, where everybody in the team, social worker, community psychiatric nurse, other doctors, usually GP as well sit and we discuss the case. As you know this gentleman, this patient is very well known in Aberystwyth. Everybody knows him, so everybody contributed in painting, colouring in the picture of the patient and his background and who he is and what has been going on. Then the conclusion then is that if he was happy that we can send a psychiatric nurse to his home and see how things are there, that is one of the investigations and to see him again in outpatient clinic after discussing it with the GP, who has to be involved as well. So, to follow the case, keeping that in mind and building the picture up. That is what the conclusion came up.

Q Did you make any arrangements to see his wife?

A His wife will be part of the picture. She will be invited to the outpatient clinic by the community psychiatric nurses. This is common procedure. She is next of kin.

Q Not something you specifically ask for, though?

A It is routine, if you like.

Q Routine?

A If she does not come the next time, it will be possibility of going seeing him with her at home or why or there is something.

Q Doctor, I know you do not accept the accuracy of the account that was given by the patient to Dr Cosgrove, but just help me with this scenario. If that account was accurate, would it show, in your view, a lack of knowledge on your part and a falling short of the appropriate standard of a psychiatrist?
A It is a big “if”. If all this is true and I was rude and I was not proper and I was that idiot, yes, if all this is true.

Q If it is true?
A Then the consequences is what?

Q That you would not have been acting competently as a psychiatrist?
A I would not have been acting as a doctor at all, not only a psychiatrist. Yes.

MR MORRIS: Thank you.

THE CHAIRMAN: Mr Pearce?

MR PEARCE: I have no re-examination.

THE CHAIRMAN: Doctor, the members or the Committee may have some questions for you.

Questioned by THE COMMITTEE:

MR MATHARU: Good afternoon, Dr AlShabnder. I have just one question for you. You received this letter from Dr Cosgrove and you told us that although you were angry with the contents of the letter, you actually said that you learned to live with the letter. I am just wondering why you did not actually take it further?
A I did discuss it with the Clinical Director. I did discuss it with colleagues in the Trust. I thought they did tell me that they will be appropriate matters taken but in what way do you mean take it further? In what way? What does taking it further mean? On what level?

Q We have heard Dr Cosgrove says you are medically negligent. Obviously it would be natural to be angry if somebody accuses you of being negligent but you actually said that you just learned to live with it, you did not take it any further. I am just trying to clarify why?
A If you mean that I take legal action - is that what you mean? It is not my way. I do not take legal action against anybody. I think it is wrong. I do not do that at all.

MR MATHARU: Thank you, doctor. That is fine.

THE CHAIRMAN: Mr Pearce, do you want to come back?

MR PEARCE: I do not want to make a speech at this stage, sir, but just in the light of the question that was raised there - and I do not want to open a can of worms but, of course, it is fair to say in terms of what action has been taken that this matter is now before this Committee. I simply make the point, without making a speech.

THE CHAIRMAN: I think the point that Mr Matharu was trying to draw out was, did any action come at the immediate time from the doctor and we hear that no immediate action took place and he has given some explanation as to why.

MR PEARCE: I understand that, sir, thank you. I have no further questions in re-
examination, sir.

THE CHAIRMAN: That concludes your evidence, doctor. Thank you very much for coming to assist us. I will be guided in relation to timing.

MR PEARCE: We are fairly optimistic, I think, that Dr Humphreys, who is the one remaining witness I intended to call today, the one remaining witness who is here, will be very short.

DR SEAN WALLACE HUMPHREYS Sworn
Examined by MR PEARCE:

Q Could you give the Committee your full name, please?
A Sean Wallace Humphreys.

Q Dr Humphreys, are you a general practitioner. Is that correct?
A That is correct, yes.

Q Where do you currently practise?
A Aberystwyth.

Q Did you practise as a general practitioner in 1999 in Aberystwyth?
A I did.

Q Could I please ask you to look in the bundle that is headed C8, which is I hope in front of you, behind tab 3. Do you there see a letter from Dr Cosgrove dated 3 December 1999 addressed to you?
A I do.

Q This letter clearly relates to a patient, a patient who we, for the purposes of this hearing and in order to preserve anonymity, are calling Patient B. Was Patient B a patient of yours?
A He was.

Q Have you familiarised yourself with this letter recently
A I have.

Q When you received this letter, what was your response to the contents of it?
A My immediate reaction was I was incredulous. I had not actually seen a letter quite like this before and I have not seen one since. Normally as GPs we tend to speed read the letters which I did on this occasion and, as per my statement, the initial part of this letter I thought was entirely in keeping with a normal GP/consultant correspondence, as it were, but turning on to page 2 and page 3 of the letter, I became increasingly concerned at the tone and the content of the letter.

Q I take it those parts that you refer to a psychiatrist, who we are fairly clear was Dr AlShabdner?
A That is right.
Q What was your concern about the content? Why was that a matter of concern to you?
A I think that the letter -- Dr Cosgrove in this letter appeared to be making personal comments about Dr AlShabdner which were hearsay, i.e., the patient had made these comments supposedly to him and also casting doubt about his professional and clinical competence. I noted at the end that a copy was sent both to Dr AlShabdner and to the patient concerned, which heightened my concerns.

B Yes. Did you have experience of Dr AlShabdner in medical practice?
A I did, he was a local associate specialist and had, therefore, seen a number of my patients over preceding years. Aberystwith is a small town and as such the medical practitioners within Aberystwith tend to know each other reasonably well.

C What opinion had you formed of Dr AlShabdner?
A I thought he was an excellent practitioner. He seemed ready and willing to see patients when asked and overall I felt the standard of his opinions that he gave to be excellent.

Q You indicate that you had concerns about the contents of the letter. Did you discuss those concerns with anyone?
A I did two things. I passed the letter around the weekly practice meeting, the meeting of the partners that we have each Wednesday to discuss business and other matters I asked the partners for their views on the contents of the letter. I spoke to my defence organisation to see what they thought my most appropriate response should be and I also asked whether I had any other obligations in terms of yourselves really.

Q I do not think we are concerned with what they may have said, but subsequently after sharing your concerns in these ways did you take any action?
A I did. I sent a letter to Dr Cosgrove thanking him for the clinical contents of the correspondence that he sent me, but stating that I was unhappy with other aspects of the letter. Unfortunately I do not have a copy of that but I have record of the fact that it was sent. I also picked up the phone and spoke to Dr AlShabdner and tried to ensure him that I had in no way impugned his reputation and that these comments were not originating from myself.

F MR PEARCE: Thank you.

MR MORRIS: No questions.

THE CHAIRMAN: Members of the panel? No questions from the members of the panel. Dr Humphreys, thank you very much for coming to help us. Not sure whether I should apologise that it was a rather short visit here?

THE WITNESS: Thank you.

MR PEARCE: My prediction was accurate. Those are the witnesses I have available today.
The availability of witnesses was discussed

The committee adjourned until 9.30, Thursday, 10 June
MR D MORRIS, of Counsel, instructed by Messrs RadcliffesLeBrasseur, appeared on behalf of Dr Cosgrove, who was not present.

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

(Transcript of the shorthand notes of TranscribeUK
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THE CHAIRMAN: Good morning. When you are ready, Mr Pearce.

MR PEARCE: Absolutely, sir, I am ready now to start with Dr Judge, please.

DR DEBORAH JANE JUDGE Affirmed
Examined by MR PEARCE

Q Dr Judge, could I ask you to give the Committee your full name, please?
A My name is Dr Deborah Jane Judge.

Q Your occupation, Dr Judge?
A I am a consultant child and adolescent psychiatrist.

Q Who is your current employer?
A My current employer is Avon and Wiltshire Mental Health NHS Partnership Trust.

Q Were you employed by that Trust in May of last year?
A I was on a locum basis in May of last year.

Q Could I ask you to have a look at one of the bundles of documents that I hope is to your right and should have written on it C8. In C8 could I ask you to look, please, at tab 10, page 7 thereof. This is, I think, a clinical note relating to a patient and his mother and for the purposes of this hearing we are calling that patient Patient G. Is this a note that you made on 16 May 2003?
A It is, yes.

Q Did you see Patient G and his mother on that day?
A I did.

Q At that time, had Patient G been prescribed Risperidone and methylphenidate?
A He had, yes.

Q By whom?
A The letter that I received from the GP and from what his mother also told me, the prescription had been made by Dr Cosgrove.

Q If we just look back in that same division of that bundle to page 3. Just so that we get a clear picture of this, you will have noted that there is an admission on this aspect of the case that Dr Cosgrove had seen Patient G and had prescribed Ritalin and Risperidone in February 2003. Do we there see reference in a letter, which I do not think you will have seen at the time but a letter from Dr Cosgrove to a general practitioner relating to the patient dated 25 February 2003 and indicating a consultation on the 24th of that month?
A Yes.

Q Returning, if we can, to page 7 and your involvement, Dr Judge, how did it come about that you were reviewing Patient G?
A Patient G had been seen some months earlier at the clinic for an assessment
session by one of the clinic child psychotherapists.

Q This is your clinic?
A Yes, so he was on the books of the clinic, as it were, waiting for what had been indicated from the initial assessment was family work and behavioural strategies and subsequently the GP wrote to the clinic with concerns about being asked to prescribe Ritalin and Risperidone together for a four year old and was specifically requesting a psychiatric review.

Q Right, so we have identified that Ritalin and Risperidone were prescribed by Dr Cosgrove. To the best of your knowledge before this date in May 2003, had anyone from your clinic prescribed Ritalin and/or Risperidone to Patient G?
A No.

Q Just looking through this note, if we may, “Mrs G and G attended. Review of medication following GP referral. Medication”

- tell me if I am getting any of this wrong, please -

“Risperidone 0.125 mg x 5 daily, methylphenidate 5 mg x 5 daily. Discussion with Mrs G of history and treatment. Happy with improvement in G’s behaviour but has lost weight, 1 kg since starting medication in Feb.”

Just pausing there a moment so we are clear about that, Mrs G was saying that her son had lost 1 kg in the period from February to May?
A That is correct, yes.

Q “Height and weight measured today in clinic. Agreed to NHS clinic follow-up with a plan for gradual reduction of Risperidone medication. Will need medical monitoring re medication. Mother also open to clinic sessions re family relationships and behavioural strategies. Risperidone 0.125 mg tds.”

Is that correct?
A That is correct.

Q Just, for the benefit of Committee, can you say what that means?
A That we agreed at that initial session that the aim of me - one of the aims of me - continuing G’s follow-up was to reduce and rationalise the prescribing and so that we aimed to start that by reducing the Risperidone medication from five times daily dosage to three times a day dosage.

Q Just for the non-medical members of the Committee, “tds” means?
A Three times daily.
Q And methylphenidate, 5 mg five times daily?
A That is correct.

Q So it is the same dose of Ritalin, of methylphenidate, but a reduced dosage of Risperidone?
A That is correct.

Q That is signed, I think, by you next to that prescription?
A Yes.

Q Then underneath that, is that three letters - does it say MSE or something?
A Mental state examination.

Q I understand. "G played with Lego and drew at the table, settled in his behaviour. Talked about school and teacher, likes school."

That, then, I think is the end of the entry for that day
A that is correct.

Q When you spoke to G - or rather G’s mother - in the course of that consultation, what did you find out about the monitoring of the medication that Dr Cosgrove had prescribed?
A She said that the further contact that she had had with Dr Cosgrove about the medication was via telephone contact.

Q You spoke about concerns, I think, at this consultation. What, if any, concerns did you have about the treatment of Patient G?
A The two broad angles of my concerns were that he was only four. He weighed 17 kg at the outset and he had lost 1 kg in weight since starting this combination of medication, so I had concerns about the impact of the medication on his appetite and growth. Then, secondly, I had concerns that he had been prescribed these two sorts of medication after one assessment appointment with Dr Cosgrove. My understanding about the use of Risperidone in attention deficit hyperactivity disorder is that it may be indicated in treatment resistant cases, so that I was concerned that this combination of medication had been prescribed after an initial consultation.

Q Thereafter did you see Patient G from time to time in the clinic?
A I have done so, yes.

Q And what was the progress of his weight thereafter?
A His weight continues to be a concern. His current weight is, I believe, 16.3 kg and I have just agreed with his mother at the last appointment that I would refer him to a paediatrician to have his growth reviewed, so it has been an ongoing concern over the last year and I have raised at other intervals whether his mother would want this additional consultation with a paediatrician but previously she had said no, but it seems now,
because his growth really has not picked up that it would be appropriate to do that now.

MR PEARCE: I understand. Dr Judge, thank you very much. That concludes the question I want to ask. Mr Morris, on behalf of Dr Cosgrove, will now ask you some questions.

Cross-examined by MR MORRIS:

Q Dr Judge, you said that your understanding was that G had been monitored by Dr Cosgrove over the telephone and I think you confirm that in your letter to the GP on page 9 of tab 10, the second paragraph.
A That is correct.

Q Then, after, if we go back to page 8, after the 16 May consultation you reviewed G with his mother on 6 June and you reduced the Risperidone to 0.125 qds - four times a day?
A Four times a day, correct.

Q Instead of five?
A Yes.

Q Could not manage to reduce further because parents felt that G was more irritable, restless, unhappy. School have not remarked on any change. Then you set out your plan in relation to the medication. 11 July, “Good school reports. After school manageable until 6.00 to 7.00’’?
A Correct.

Q Then, “Medication regime. Methylphenidate remains the same.” Is that right? Five times a day at 5 mg?
A That is correct. That is the current, on that date, yes.

Q Did you change that? We do not have a continuation of that.
A Can I refer to his clinical file? I have the copy of his clinical file with me.

Q Yes, if you want to complete that day’s consultation notes.
A I read out how it continues on the next page:

“Weight loss, appetite a problem. If anything eats most last thing at night. ‘Seems to be sprouting thin blond hair all over’ in quotes, from his mum. Plan, shift dose regime. Query refer to community paediatrician due to weight loss. Staying with grandma in Teesside for six weeks over the holidays. Plan to review weekly by telephone contact whilst he is there and the methylphenidate to be shifted to three times a day 5 mg and 10 mg at night”

So I began to shift the timing of the doses but did not change the total amount of methylphenidate.
“The Risperidone to be prescribed at 0.125 mg four times a day. Aim for both three times daily, decrease evening methylphenidate.”

So, that was advice given in the meantime over that six week period, that if the family felt that they could reduce the medication further, then that was advised.

Q If I can just follow through in your notes over that summer, I can help the Committee, I have copies of the extract I wish to refer to.

THE CHAIRMAN: This will be D26. (Produced)

Q You see G again on 17 July, as you say, you shifted the methylphenidate to three times a day but the same total amount?
A That is correct.

Q And Risperidone twice a day, again with the same total amount of half a milligram. Is that right?
A That is correct.

Q You already mentioned that G was going to be away in the summer and you say: “Away now for the summer but mother will keep in telephone contact”, then did you monitor his situation by telephone over July and August? I think there was a missed contact on 31 July?
A Yes.

Q Then on 7 August there was telephone contact. You repeated the prescription. If we look over the page that I have copied, further on in your notes, it is attached to the page I have had copied as a telephone note of that was conversation.
A Right.

Q Do you have that?
A I do.

Q In relation to 7 August:

“Appetite hasn’t changed. Breakfast serial x 2 at 9 p.m. 16 kg - weight static. Half tablet Risperidone. Can be hyper & exuberant. Tearful at times. Peaks & troughs. Sleep. By 10 p.m every night - improvements.”

You were monitoring his weight and monitoring his behaviour and condition on that regime?
A Yes.

Q And if anything untoward by way of side effects or anything had been reported that would be obviously something you would wish to know?
MR MORRIS: Thank you very much.

MR PEARCE: No re-examination, sir.

THE CHAIRMAN: Check if there are questions from members of the panel. There are no questions. That concludes your evidence, Dr Judge. Thank you very much for attending. As I say, it is a pleasure to get clinical notes that we can read.

MR PEARCE: Sir, I call Dr Moses. Her evidence relates to Patient C.

Dr KAREN WILHEMENA MOSES affirmed
Examined by MR PEARCE

Q Could you give the Committee your full name, please?
A Karen Wilhemena Moses.

Q Are you a consultant in child and adolescent psychiatry?
A I am, yes.

Q From 1992 until the year 2003 were you employed by Gwent Community Health Trust in a post as a consultant in child and adolescent psychiatry at Saint Cadoc’s Hospital in Newport?
A Yes, I was.

Q We are concerned with a patient whom we are calling Patient C?
A Yes.

Q So that we can identify what we are involved with, can I ask you to look at divisions four and five in the bundle headed C8 to your right. We will go through the letters in some little detail in a moment, but for background, 29 May 1999, division four is a letter from Dr Cosgrove to Dr Rackham, who is a General Practitioner relating to the person we are calling Patient C, who is clearly a patient of Dr Rackham’s. It is a letter copied to you on the bottom of the letter on page two and refers in the second full paragraph on page two to the fact that you have seen this patient. If you turn over to division five, page one, there is a letter from you to Dr Cosgrove dated 1 July 1999, again about this patient:

“Thank you for sending me a copy of your letter on this boy. At the time you saw him he was a day patient on our Children’s Psychiatric Unit.”

A Yes.

Q What I want to ask you is what involvement had you had in the care of Patient C whilst he was on that unit?
A I was consultant to the unit, so that as part of the multi-disciplinary team we were looking after Patient C on a day patient basis. He attended the unit from 9 until 3.30, five days a week and attended the school. He was being assessed and treated. We were
keeping constant records of his behaviour on the unit and we were managing him with
behavioural techniques because he was seen as a youngster who would be likely to
respond to that. We were looking at all possible explanations for his difficult behaviour
and this was thought to be the sort of behaviour that develops in young people who have
not had appropriate environments, appropriate training environments and we were trying
to put that right.

Q That clearly covers your involvement during the period that Patient C was on the
unit. Had you had some involvement with his care prior to that?
A Yes, I had. I had initially seen him when he was nearly six when his mother
brought him with a variety of complaints that seemed to focus mostly around his
behaviour when we had contact with his father from whom she was separated. So the gist
of that meeting was that this was a younger who was not too bad on the whole but when
he met his natural father his behaviour was more difficult to manage. I did not think at
the time that that met any psychiatric diagnosis and did not think that the child needed
further psychiatric follow up. The child was then re-referred by the GP about a year later.
He saw my SHO at that time, she was also unable to make a clear diagnosis. She did ask
for school reports and then unfortunately she became sick so that there was a considerable
delay before this youngster was seen again because the junior doctor was off sick and
I was taking on her work as well as mine and his next appointment was postponed by a
couple of months.

Q Did you then see him?
A The next time I did see him was in the summer, in the August of 1998, seen for
the second time as an out patient by me in the August of 1998. Mother was expressing a
lot of discontent about how this boy was getting on at school. She was not happy about
the feedback she was getting from the school, she was wondering about moving him and I
did not feel that it was possible to get any proper school information at that time on which
to base any diagnosis and I postponed my next appointment with him to the end of
September on the basis that I would then have a month’s school assessment to go on as
well as what mum was telling me about him at home.

My third appointment with him was then at the end of September in 1998 when I did have
information from the school to say that he was extremely difficult to manage. I had other
ongoing concern about him at school and at home. I had the information that, I think, by
then had been in three different schools. I felt though that those were criteria for bringing
him as a day patient to have a careful look at him because he was obviously in quite
serious difficulties.

Q We have the history you saw him thee times before he came on to the unit as a day
patient. Your SHO saw him once before she went off sick?
A That is correct.

Q Could I ask you then, returning to the correspondence to which I have already
referred, division four in the bundle, the letter of 29 May, 1999. I have referred to the
paragraph in the middle of the second page of the letter in which you are mentioned.
Mentioned that you were seeing him and you will see the sentence towards the end of that
paragraph:
“I am surprised that not more has been done for this poor child by the local specialist.”

What was your response to receiving a copy of this letter from Dr Cosgrove?
A

I felt that there were a number of aspects that suggested that Dr Cosgrove had not understood and been aware of the actual facts of the case and that he had drawn conclusions and make disparaging comments the basis of really quite false understanding. I also felt from the tone of the letter that he had not even understood that Patient C was a day patient on a psychiatric unit at the time that he saw him. I thought that if that was the case that was a rather negligent assessment of a child.

Q Can I ask you then to look at page one of division five. Did you then write this letter to Dr Cosgrove?
A Yes, I did.

Q There is another letter of that same date, 1 July, 1999 which I would like you to have a look at. This is not in the bundle (same handed).


MR PEARCE: I am obliged. Just reading through this letter, if we may, Dr Moses, this is a letter we see, the second page of which is a letter from you and on the first page we see it is to Dr Rackham, the general practitioner, I think, of patient C
A Yes.

Q The letter reads:

“Dear Dr Rackham,

Further to your telephone call this week, C was admitted to Pollards Well just before Christmas 1998.”

What is Pollards Well?
A That is the children’s psychiatric unit.

Q Yes.

“He had shown severe behaviour problems at school for some time and was very disruptive and refusing to work.

On the unit it was clear that C’s behaviour was oppositional and that he was inclined to be aggressive. His mood was variable and at times he would comply with what was being asked but when, in a less good mood, he presented a considerable difficulty to management techniques.

We were managing C by means of behavioural programmes and had not felt that drug treatment of this youngster was appropriate. He was not seen as having an Attention Deficit Disorder but rather of
having a conduct disorder which we understood partially in terms of his life experiences.

Unfortunately, when C’s mother took him to see Dr Cosgrove, staff felt that their behaviour management of C was entirely undermined. I could only agree with this, in particular as C’s response on the morning after he had seen Dr Cosgrove was to explain the piece of aggressive behaviour by saying that he had ADHD, as if this excused him from any responsibility for his behaviour.

C was thus discharged from Pollards Well prematurely, in that we were expecting to work with him until the end of the summer holiday. C’s mother was quite happy about his discharge from the unit at the time, though I fear that the fact that he has no school placement will create difficulties in the future.

I do not feel able to continue C’s care under the present circumstances and are therefore discharging him back to you.”

Can I ask you to explain that letter a little further? Why was it that you felt no longer able to continue with C’s care?

A From my own clinical judgement and that of the whole multi-disciplinary team, it was not considered that C was suffering from ADHD and so the appropriate treatment for him would not have included Ritalin or Risperidone. Dr Cosgrove had put him on both these medications and it is often not possible to continue being responsible for the care of the patient if another doctor has started treatment which is at odds with what one’s own clinical judgement would suggest.

Q Could we just understand a little further? Why do you say they were at odds?

A It was not that we had not thought of a diagnosis of ADHD. It would be one of the things that we would certainly be considering in a difficult youngster, but time and again C’s behaviour did not show signs of characteristic of a diagnosis of ADHD. I would not have felt it appropriate to treat him with these medications. The basis of our management of him was behavioural; we were trying to retrain him, re-educate him, in appropriate social behaviours and children do not necessarily take the attitude that C took that “It’s not my fault”. This lad had already been very much in the habit of refusing to take responsibility for his actions so that the medication was not only counter to what I thought was appropriate but it also made it virtually impossible to proceed with our own measures because he simply said “It’s nothing to do with me. I’ve got ADHD, behavioural management is nothing to do with me. I can’t help it”.

Q I follow. Could I then refer you, if I might, to pages 2 to 4 of division 5 in the bundle? The letter dated 7 July from Dr Cosgrove to you, Dr Moses: I think you are familiar with the contents of this letter, is that right?

A Yes.

Q I read this letter out in full to the Committee yesterday and there is no need to do it again now, but there are certain points in it I would like to take you to if I can. First of all, in general terms what was your reaction to receiving this letter?
A I was surprised and I was very taken back that any doctor could write what I thought was such a wholly unprofessional jeering letter to another doctor. I was extremely upset to see that he had sent copies of it not only to the GP but also to the mother and dad of patient C, because that was, to me, totally counter to what I thought was appropriate medical behaviour. My understanding had always been that however much one disagrees with the views or management of another colleague that it is not appropriate to ridicule and disparage that colleague by including them in any letters to the patient or patient’s parents. I was very taken aback by it and that is why I drew it to the attention of the GMC.

Q I understand. In point of fact, when did you draw it to the attention of the GMC, do you recall?
A I believe it was initially in 1999. Sorry, I have not got a chronology here. It was 2 August 1999 initially, although I did not couch that formally as a complaint, I had assumed that one could ask the GMC for a sort of informal ruling and so I sent them the letter and said I was unhappy about this.

Q It is my fault for leading you into this area. We know that one way and another the Committee, from their general dealings in cases such as this and from some of the evidence that was heard in January of this case, know a lot about complaints proceedings and what goes on, but I simply wanted to ascertain when it was you first complained to the GMC and you say it was 2 August?
A Yes.

Q I am obliged. Taking you back to the letter, just taking you to some specific parts of it. On the first page of the letter, the page with the number 2 at the bottom of it, halfway down:

“In regard to 1)”

which is:

“I did not elicit the fact that L was a day patient on your Children’s Psychiatric Unit”,

“I was told by the GP, Dr J P Rackham, that C ‘has been under the care of Dr Karen Moses at St Cadoc’s Hospital’. Put like that it could mean that he has been under your care but he is no longer. But anyhow, even if C was still under your care, the GP is entitled to ask for a second opinion and hence he states at the end of his referral letter to me: ‘I would be grateful for your opinion’.

Just so that we understand that, were you complaining that the general practitioner was asking for a second opinion? Was that the complaint you were meaning to make, or the comment you were meaning to make?

A It was part of it. I did not feel and I do not feel that it is appropriate for a GP to refer a patient to a second consultant when they are already under one consultant. It does happen, but it is not good practice. It seems even more bad practice when that patient is not just under outpatient care but he is in a day patient unit under the care of a team.
Q Moving on in the letter:

“When I met Mr & Mrs C (C’s parents) I was told that C had been attending St Cadoc’s Hospital five days per week since November 1998.”

I think that would be right, would it?
A Yes.

Q Reading on:

“I was also told that in the time of some six months, you had seen C only once.”

Was that correct?
A No, that was not correct. I would see the children on the unit informally quite frequently. I do not know what that “once” refers to. We had two other sorts of involvement with the children: one was monthly reviews, which involved the families, at which I was sometimes present but sometimes it was left to the senior nursing staff or the junior doctors; the other was weekly team meetings, at which I was usually present, when we discussed the children but we did not bring them in – we do not have that practice.

Q So C’s parents may not have known of all your involvement?
A They might not have known that, and I think one might have assumed that the one review which they attended that I was in was the only time that I saw him.

Q Would they have known that you saw C informally?
A No, they would not.

Q And you say that was with some frequency; approximately with what kind of frequency would you see the child?
A Weekly. I would be on the unit a couple of times a week and in the school and the children would be about, and it was a small number – there were only about 12 children – so that one was aware and would see and be aware of them quite readily.

Q Thank you. Moving on in the same paragraph:

“You had told his parents that you were going to prescribe a sleeping tablet at night for C. This never happened! You neither prescribed this medication you had promised nor did you explain to his parents why you had changed your mind and were longer going to prescribe it.”

A That is completely untrue for me, but I note in one of the review meetings that the person that led the review had queried sleep problems and medication, but I am afraid I cannot make out from the signature whether that was a senior nurse or a junior doctor. It would have been a review that I was not present at myself.
Q Had you yourself at any stage had any dealings with the issue of sleep?
A No, I did not.

Q We see some comments about the sources of Dr Cosgrove’s information and the relevance of that at the bottom of page 2. At the top of page 3 he said that he knew he was a day patient on your unit. He goes in that first full paragraph at the top of page 3 to say:

He had been there for six months; you had seen him only once”

- you have dealt with that -

“and he was getting worse and worse when he should have been getting better and better.”

Can we deal with that sentence in two parts? First of all, was he getting worse and worse?
A No, he was not getting worse. I have looked very carefully at the nursing notes and he was very variable. He would have several good days and he would have times when he was every bit as difficult in March as he had been in November. But the general trend was that the nurses felt they were beginning to bring his behaviour under better control, and one of the things that would happen on the unit was that if a child was simply getting worse and worse the nursing staff would bring that to attention because they were certainly not happy to proceed with that sort of situation. One of the best indicators of how a child was doing was or should have been was how often he got sent home, and I note that C was sent home from the unit a couple of times early on but I do not see any notes of that later on his admission. So I would say he certainly was not getting worse but his behaviour was variable but that overall there was a trend to its improvement.

Q The second half of what I was going to ask you was, is it right to say he should have been getting better and better?
A Well, there is no basis to say that as many children with conduct problems do quite badly even on a unit such as ours. It was certainly not possible to deal with all the children with conduct problems. What the child has already learned and the child’s current family environment and the general environment would play a bit part and we certainly did not ever suggest that, nor would any other child psychiatric unit suggest that they are going to improve every child with a conduct disorder.

Q Carrying on into the next paragraph, references this “You are unhappy about my intervention with this boy”. I think you have explained why you were unhappy and there is no need to go over that. But the third sentence of that paragraph:

“After all you told the parents that you agreed with C being prescribed Ritalin.”

Was that correct?
A I am not sure where you are.

Q I am sorry, it is the second full paragraph, the third sentence of that:
“After all you told the parents that you agreed with C being prescribed Ritalin.”

A I most definitely did not and nor did anyone else from the service, as far as I can see. There was no occasion for them to have been told that by anyone from our service.

B Q The next sentence:

“If you agreed with the prescription of Ritalin, why did you not prescribe it for him…”

And I think you have explained what your management was. The next two paragraphs deal with why you should be joyful and happy because his condition had improved following the prescription of Ritalin. Did you have any first-hand knowledge of what C’s condition was after he left, after he stopped staying in the unit and was discharged from your care?

A No, I did not.

Q Taking you to the bottom of page 3, the next paragraph of that page:

“As regards 3), you are most unhappy with my false assumption that ‘not more has been done for this poor child by the local specialist’. You first saw C when he was 5 years old when he was not eating, was thin, was having frequent tempers and when the parents were being called into school on a weekly basis.”

First of all, that would correspond in age terms with the time of the first attendance; you said nearly 6 for his first attendance?

A Yes.

Q So he would have been 5?

A Yes.

Q Do you agree with the description that is given there:

“Not eating, thin, frequent tempers, parents being called into school on a weekly basis”?

A Some of it but not all. Would it help if I...

Q Yes.

A It was mentioned that there were problems with eating, which mother told me she thought was probably due to the fact that his father had been in the habit of throttling him when he would not eat before. When she actually came to me, this was not a problem and as I have said at the beginning, what mum was thinking was, to me, that his behaviour was difficult was after he had had visits to his natural father and it sounded, that was the main gist of that, that it sounded like an issue over contact which mum had about the boy.

Q It is said that you made no diagnosis. Is that correct?
A That is right and that is used in this sort of critical way, but it is perfectly valid to make no diagnosis if there is none to be made.

Q It is said that you did nothing that actually resulted in alleviation of this child’s malfunctioning?
A That is also right and the degree of his malfunctioning was not at all clear and not at all very marked. I thought at that first appointment, it is not unusual to have a parent come who wants to do something about contact between their child and the estranged parent and it read very much like that sort of situation, where I was being told that this child was functioning badly after contact and that that was the issue.

Q You saw him again when he was six years old and had one half hour’s talk with C’s mother. If that is the second visit, would he have been six when you saw him the second time?
A Yes, I think he was six, yes.

Q When he saw the SHO or when he saw you?
A Yes, this was April 1998, actually, that he was seen by the SHO.

Q His date of birth is 27 July 1990?
A Yes.

Q We can look at it I the original - I know it has been crossed out but you can look at the records if needs be. That would be that he was seven then, you say, in April 1998 and that was which attendance, sorry?
A That was the second attendance.

Q When he saw you? The second time he saw you?
A The second time he saw me was August, I think, August 1998.

Q There is reference to that being a one half hour’s talk. Assuming it was his second consultation with you, would half an hour be a reasonable estimate of the length of it?
A Yes, it would. It was a follow-up, really, for what should have been a follow-up by the SHO and that would very likely have been half an hour.

Q There was a similar meeting, it is said, when he was seven years of age, so you had seen his mother three times in four years. It was September, you said?
A That is correct.

Q The third meeting, so he would have been seven then. “What did you actually achieve by these three meetings?” asks Dr Cosgrove. I think you have described that to us already. I do not know whether you feel that you can add to what you have said?
A I feel that the nature of child psychiatry work is that one often achieves part of an assessment at a meeting and these had been three rather disparate meetings. The first one was discontinuous with the others. The second was a follow-up of the session that my SHO had started. To do anything about him at that time would have needed school reports and assessments which were not available in the summer and so I waited until the third one, when they were available, when I took a measure which was already quite extreme and there are only, as I say there are only about twelve spaces there, I admitted
him to one of twelve spaces in Gwent because I could see that there were serious
problems but I did not think they were problems to be diagnosed or to be giving
medication to on an outpatient basis without further assessments.

Q I see. Moving on to the next page, the top paragraph, Dr Cosgrove says
something about C’s behaviour at school and the fact that he was expelled from Durand’s
Primary School after one month because of violence to other children. The last sentence
of this paragraph says:

“Nothing you did or said on those occasions”
- the times you saw him -

“prevented his behaviour causing him to be asked to leave from
two schools last year and from being admitted to St Cadoc’s.”

It rather follows from what you say that you would essentially accept that and certainly
you would not say it was a criticism?
A That is correct. It is very often the case that one cannot put all these things right.
It is quite mistaken to assume that if a child is going on having problems, that can be
attributed to lack of appropriate help. Sometimes it is not possible to do anything and he
was still being assessed.

Q The next paragraph I do not need to ask you to comment on. You have
commented on the matters relevant to that already. Finally though, in what is the
penultimate paragraph of this page, he says this:

“I note that your letter is headed in bold, black capital letters
‘Restricted and Confidential Information.’ You are a public
servant being paid by public monies and employed in a public
service. You are, therefore, publicly accountable and I will not
have correspondence going between you and me that disallows
the parents from knowing what is being said about them and their
son, C. I have ignored this restriction by quoting verbatim from
your letter and by sending a copy of this my letter to you and to
Mr and Mrs C and to Dr Rackham.”

You have commented already about the letter being sent to the general practitioner and to
the parents but can you explain why it was that your letter was, indeed, as we can see,
headed in bold capitals, ‘Restricted and Confidential Information’?
A Because that is the practice in the Trust for which I was working then and the
practice in the majority of similar Trusts. It was not of my doing. I would agree with it
but it certainly was not of my doing and it would have been very difficult to have altered
that.

Q Why this particular letter? Presumably not all letters are so headed?
A Yes, they are.

Q They are? It is a standard heading?
MR PEARCE: I understand. Thank you. I have no further questions for you, Dr Moses. Mr Morris on behalf of Dr Cosgrove may have.

Cross-examined by MR MORRIS:

Q Dr Moses, would you agree that it would appear from this letter of Dr Cosgrove’s which caused you to complain to the General Medical Council, it was effectively Dr Cosgrove being an advocate for the parents and reporting to you what he had been told by the parents, or the mother, perhaps?

A Are you referring to the one on Section 5?

Q The 7 July 1999 letter, yes?

A No, I do not believe that this was in any way his being an advocate for the parents. I felt that this was him having a very aggressive go at me for simply telling him that I was not entirely happy about what he had said and my relatively mild rebuke.

Q Obviously his criticisms of you are one thing but as far as the facts of the matter are concerned, it would appear that he was reciting what he would have been told by the parents, would it not?

A In the first letter, certainly.

Q Certainly in the first letter?

A Yes.

Q I just want to look at little closer at the history of the child during this period and see how accurate or not the parents’ recollection was and also to look at the issue of signs and symptoms of attention deficit hyperactivity disorder. I have had copied some of the entries - not all - in the child’s notes and I would like you to have a copy.

THE CHAIRMAN: This will be D29. (Produced)

MR MORRIS: I am afraid, doctor, that we do not have these notes in chronological order, so we are going to have to skip around between pages. The pagination is at the bottom right. There are gaps in the pagination but at least the pagination follows in sequence. 77, the second page. This is a consultation. Is this your writing?

A It is, yes.

Q I think this is when you saw the child on 11 July 1996 when, as you say, he was five, nearly six. If we look at the bottom of the first page, there was a report from the school:

“Seen not to concentrate, slow progress”

- please correct me if I get your writing wrong -
“But does not seem to be a major management problem. Some aggression at school with others, doesn’t get on very well with other people.”

Over the page, 78:

“Has pleasant times but can be very irritable and then aggressive”?

A Yes.

Q I think you wrote a letter following that to the general practitioner and we see that at page 148, 1 August 1996. You set out what you had recorded in your clinic notes. The second paragraph:

“As far as school is concerned C is thought to have problems with concentration and can be aggressive to other children. Not seen as a major problem.”

The final paragraph on the next page, you bring up the discussion you have had about the question of contact with the father and concluded that you did not see any other remit for child psychiatric intervention?

A Yes.

Q And had not arranged for any follow-up. He is being referred back, if we look back to page 147, by his general practitioner to the service in March 1998 and he sees, I think you said, your Registrar. If we look at 144 and 145 there is a letter from Dr Napier, your Registrar?

A Yes.

Q Is that to whom you are referring?

A Yes, it is.

Q Then at that time the complaint was the mother, of difficult behaviour and overactivity and in the background a history of aggression and disruption, being quite destructive both to himself and to material possessions:

“Things are also difficult at school. He is disobedient in class and disruptive and does not work, either in class or do his homework. His mother says he is very restless and is unable to watch a video all the way through or to concentrate and play on computer games. His mother feels he is constantly seeking her attention.”

The inability to concentrate and the restlessness, those would be signs of attention deficit hyperactivity disorder, would they not?

A I think that is exactly where one of the huge difficulties here lies, that inactivity and recklessness are very general behaviours that are present in large numbers of children, particularly at quite young ages and what underlies them and how constant they are is very critical in deciding whether you give the child a diagnosis of ADHD or
whether you understand the restlessness and activity in some other way.

Children who have had a very disturbed background, as this young lad had, may well be overactive and restless for reasons other than that they have ADHD. It is one of the difficulties that causes confusion for parents, because they will read in magazines that restless, overactive children have got ADHD and can be helped with medication and if we treated everybody, every child who was restless and overactive with medication, we would have 10%, 20% of children on medication, which generally people would agree is inappropriate.

The difficulty here is that one is using a very general term and then actually using it also to make a specific medical diagnosis which warrants medication. So, even on Dr Napier’s description where she mentions concentration, it would be quite wrong to conclude from that that this child has ADHD. It may be quite appropriate to look a bit more carefully, to keep an eye on him at school. It would be appropriate to give the school a questionnaire to do to see how he rates on a whole specific block of questions about behaviour related to ADHD, but it would be wrong to conclude ADHD from that description.

Q  Let us continue. Going through the report under “Schooling” on page 145:

“As mentioned previously C is disruptive and disobedient. His teacher feels that he is below average ability and he is due to see the Educational Psychologist.

Development”

- a description of the pregnancy -

“He was born normally and achieved his milestones when expected. C was co-operative but fidgety and restless.”

That would have been a description of him at the consultation, would it not?

A  Yes. It is put rather oddly there but it does look as though it is from what follows.

Q  The plan:

“In Summary

C is an eight-year old boy who has behaviour difficulties and finds his emotional problems superimposed on a difficult family background. He is also overactive and appears to have quite poor concentration. I plan to request a school report…”

I think you then said that there was a hiatus because of your Registrar’s illness and if we go to 139, Dr Napier confirmed that in July 1998 and effectively passes the care of C to you?

A  Yes. You will notice that that letter doing that is a letter to mother’s solicitors because it was the solicitors at that point who were, if you like, trying to get some
movement because they wanted a report relating to this boy’s contact with his father.

Q Right. Then I think you see him for follow-up and I think we have your report of that at 134 and 135?
A Yes. Can I mention paragraph 2 there, which is in error.

Q You want to mention paragraph 2?
A Paragraph 2 is in error because I have looked back at the notes and I have said in paragraph 2 that mum said that she had considered transferring C to Mounton House School. It was actually teaching staff who had considered that. Mounton House School is a residential school for children with difficult behaviour and mum had already said to me in a previous meeting that she did not want him at Mounton House and it was the teacher who had said that, not mum.

C Q She was dead against that?
A She did not want that, yes.

Q You concluded that letter by saying that you had:

“…difficulty in pinpointing the issues here, together with C’s imminent move of school I thought the most appropriate thing would be to ask for a school report… and review towards the end of September.”

We see, I think, your notes at page 66, the first page of this bundle. You mention a telephone call to the school. Is that 24 or 29 September?
A 24, I think.

E Q 24 September.

Q Was that at the school’s request that you telephoned or was it---
A No, at mother’s request. She got in touch with the secretary to say there were problems.

F Q The problems were, if you can help us with what she had noted there:

“In school - 3 days
Then holiday for 1 week.
Since then major problems.
He just won't do anything.

G Class of 34. He tries to disrupt entire class.
Howls, bangs his head and breaks things.
Was aggressive and rude at St Mary’s
But he had done some work there.
Is above average IQ?”

H And how does the note continue?
A It says that the only time he will work is if it is before lunch and the teacher insists, i.e., “You can't go to lunch until you finish this piece of work”, then he would do his work.

Q “SN”? Special needs?
A Yes.

B Q “…option to be pursued”?
A Yes.

C Q “She feels place at”?
A That is Mounton House.

D Q “Would be best.”

Who does “she” refer to?
A This is the teacher, Mrs Edwards.

E Q I think the plan is that you are going to see the child on the 30th?
A Yes, that is correct.

F Q Then if we go to 131, report of your consultation appears to have been on the 29th and you recite your telephone call there, do you not, with the teacher, experiencing major problems, refusal to do any work, disruption of classes, etcetera. Then in the third paragraph you set out mother’s problem:

“Although she experiences difficulties with C at home these are not at all on the scale of the difficult behaviour he shows at school. …mother brought along some of C’s school work, and it does seem that he has a rather variable range of abilities.”

So it appears from what the school were saying that he was above normal IQ but not performing to that level of intelligence?
A Interestingly that contradicts a previous school view, which was that he was of low ability.

The most likely conclusion one would draw from that was that he has rather mixed abilities and as with a lot of youngsters their verbal intelligence, or to participate orally is much better than their written work and that causes confusion and emotional difficulties.

G Q You decide that because of these serious problems he should come in for assessment to Pollard Well?
A Yes, that is right.

Q We see the internal referral, page 119, I believe that is signed by you:

“Description of main problem:

Mainly severe behaviour problems at school – Disruptive, refuses to work ‘howls’, probably a learning difficult issue with behaviour secondary.

Specific goals/aims:

For assessment – general, educational
As clear cognitive valuation as we can.”

Then I think his first day at Pollard's Well, to get the exact date, if we look at 186, the nursing notes, 3 November, it may be 13, you have the originals there?
A No, no, I do not have the originals.

Q Sorry. I do not know if you your copy would assist any further as to whether that is 13 or 3 November?
A No, it does not.

Q Some time in November he attends and that looks like the first day. The second is the following entry, 4.11.98, and you say that you would have seen the child on an informal basis from time to time during his stay there?
A Yes.

Q But did you make any notes of your view of the child---
A No.

Q ---during the informal viewings?
A No, that would not be normal. What this was was very much a multi-disciplinary assessment to which everyone contributed and the notes that were made would have been ward round notes mostly and teaching notes, he would have spent essentially all his time in the school classroom with the teachers.

Q While he was there you were asked by mother’s solicitors to write a report and you delegated that to one of the senior nurses there, Mrs Pope. I am sorry, I am looking at page 128?
A Yes, I tried to and Mr Pope agreed to do that but he was then informed by the hierarchy that he could not do so, so it was I who wrote the brief report in the end.

Q In writing that report you comment:

“My own reporting on C, of course, depends on the observations of number of other staff on the unit”?
A Yes.
A
Q So you were not able to rely on your own observations in relation to making that report?
A No.

Q So would it be fair to say you would not have seen anything of any clinical significance in your informal tour of the units?
A I think it is very difficult to see behaviour disorders in the course of small contacts. Where you see them is when you are in continuing contact with the children and it is inevitably the nursing staff and the teaching staff who have that contact. That is the part of the purpose of independent (Inaudible) like this is that at least somebody of a trained professional nature does get sort of exposure to the child which will allow them to draw some conclusions. Otherwise my position is almost always that I am working only on other people's observations. With this sort of a diagnosis I do sometimes see children who are very obviously ADHD, who one can see that when sitting with them for half an hour. But it is much more often the case that what is observed is in the course of the day and I would not see that, no.

Q Then if we go to page 127, this is a home visit carried out by Staff Nurse Pope, I do not want to go into the detail of it, but the final paragraph the nurse comes out with his suggestions:

D
“Suggested that boundaries is need to be far more consistent, as this would give C a sense of security. Also suggest that uproar in C’s life may have caused him to have quite low self-esteem. To this end it was agreed that appropriate praise should be given. The suggestion was made that C may benefit from a behavioural programme and after this was agreed to by mother it was fully explained it would begin on 8 February 1999. The overall impression was that of a family struggling with a difficult boy and in desperate need of guidance.”

A Yes.

Q Then can I take you to the part of the nursing assessment at 115. There are a number of elements of this, I have picked out this one under cognitive development. Just help us with this, the actual assessment is the top box, is it, then commentary at various intervals?
A Yes.

G
Q And the only row that it is marked is in relation to play:

“Play is chaotic
5 4 3 2 1”

Which way does the spectrum go? Can you help us with that, Dr Moses?
A It is an unusual way to do this. Usually it goes, one would be the least chaotic, so that four is on the high end.
Q Then other side of that row:

“Follows a task through from start to finish.”

This is in the “Assessment Score +” column:

“1 2 3 4 5”,

again, how should we read that?
A Again, that he does not score very highly on that. I think they have done it this way so that the minus scores will be -- so that the joint score will make more sense.

Q Then looking at the nursing commentary, there appears to be a divergence on dates, on the one month comments box we actually have the date of the nurse’s signature as 4 March 1999, which would be at least three months after he had arrived on the unit. That would be correct, would it not?
A Yes.

Q “C’s play again shows a quite erratic pattern depending on his mood. He either plays well and enjoys it, or is completely obstructive. He appears to have no coping mechanisms to control his behaviour.”

Then a subsequent comment, and we do not know when that was, but presumably some time after 4 March, from another nurse:

“C likes to take the lead. When things don't go his way becomes completely disruptive, disrupts the whole group.”

If I can take you to over to page 118, which is another report from the Staff Nurse Pope, this is a request is it not for assistance to be given to the mother by social services?
A Yes, I believe it is.

Q Unfortunately it does not appear that this letter is dated.

THE CHAIRMAN: Dated 27.7.90?

MR MORRIS: I believe that is the date of birth, is it not, Dr Moses?
A Yes.

Q Final paragraph:

“Present home situation is very difficult as mum has quite a severe illness and is finding almost impossible to cope with C’s increasingly problematic behaviour. Obvious we at Pollard’s Well are doing what we can, but we are limited as regards both timescale and resources and I would be grateful if you could contact me regarding this.”
I do not know whether you can tell from the position of this letter in the notes as to when that might have been written?

A I believe it was quite late after Mr Pope’s home visit to the family.

Q I was going to make that suggestion. It would probably have been after that visit. We know that was February. Would it be fair to say, having run through those extracts from the notes, Dr Moses, that your staff at Pollard’s Well were not having much luck with this boy in terms of treating him?

A Yes, I think we certainly had not by any means sorted this problem, but I would emphasise that it is not at all unusual with children with marked conduct problems. We never suggested that we were a unit who could admit these children and put them right. What we felt was important was to do a good assessment, make sure there was nothing treatable being missed and do our best with behavioural methods and help the family, but that sometimes we would fail and that was not peculiar to the unit that I worked in then.

Q Can I suggest that by this time, given the factors that we know about in this child’s history, the possibilities of ADHD and the need to consider medication should have arisen within the teams consciousness?

A Yes, it certainly would have done. We had quite number of youngsters through the unit who would be seen as exactly that, as having ADHD, and we would use the admission to get them on to treatment and assess their responses. That is why I mentioned this was not an oversight. It was not that nobody thought about it. It was that he did not present with the sort of symptom profile that would make this a likely diagnosis.

Q I think you said that time and again he was not showing signs of ADHD?

A Yes, that is right.

Q Is that right doctor?

A Yes.

Q Can I put this scenario to you and see what you say to it in this context, that there is an early onset and highly persistent pattern of poor behaviour, poor academic process in the school, in spite of a normal intellect, an account from the mother of being very restless, nursing reports and observations that he was chaotic in his play, unable to control his temper, rather than using it to obtain desired ends. All those factors would suggest a possible diagnosis of ADHD, would they not?

A They are not specific factors and they are not very much pointing towards ADHD. If you notice throughout the observations, C was at times able to concentrate. I said he varied a great deal – he would have days or several days when he would concentrate, he would follow the rules, and then he would appear to be in a different mental state – he was more restless, more irritable, far more provocative, far less easy to control, and that very variable picture is very much not consistent with ADHD. Children with ADHD are not able to concentrate/settle and they do not have very good days. This lad did have some very good days. When he first came in, interestingly, he presented very little problem for a while; he was quite manageable. The schoolteachers, who were enormously experienced with ADHD, never saw his key problem as being attention deficit disorder. I think there are a lot of children who are disturbed who also do not attend very well and do not concentrate, being very anxious, being upset, being
emotionally upset, and/or being unable to do with work, all upset concentration, but that does not allow one to make a diagnosis of ADHD and it certainly would not mean that the child should be treated with stimulants.

MR MORRIS: Thank you very much.

MR PEARCE: I have no questions.

THE CHAIRMAN: There are no questions from the Committee, so that concludes your evidence, Dr Moses. Thank you very much for coming to assist us.

(The witness withdrew)

THE CHAIRMAN: Could I suggest we have a break and reconvene at 11.35?

MR PEARCE: Yes. You will hear the hesitation in my voice, and the hesitation is this. We have four witnesses lined up to give oral evidence this morning, with the plan being two this morning and two this afternoon. We will make investigations as to when the two this afternoon are here; they are from Cardiff, I think, both. They may be on their way; if they are already here, clearly we will go into that evidence. If they are not, we will let you know what the position appears to be at 11.30.

Can I say this? I do not know what my learned friend thinks but I am increasingly confident that we will finish that oral evidence today.

THE CHAIRMAN: There may be good reasons but I think it is unfortunate that the witnesses are not here, knowing that they were to give evidence today – and I fully accept the unpredictability of the timing. It seems to have been a pattern of this hearing and the previous hearing that we do not seem to be able to utilise our time totally effectively. But if they are not here, they are not here and we cannot proceed. Do you have any information about the witness who was being called at the beginning of the week?

MR PEARCE: Yes, we can work out her attendance so that that is on Tuesday morning.

THE CHAIRMAN: That is very good. Could I also suggest at this point, in that case, a 10 o’clock or 10.30 start if she is the only witness?

MR PEARCE: She will not be the only witness on Tuesday, as I understand it. I think my learned friend is going to call two witnesses on that day as well.

THE CHAIRMAN: So we will aim to start at 9.30 then.

MR PEARCE: I think Tuesday will in fact be a useful day.

THE CHAIRMAN: It certainly sounds as though it is going to be a fuller day than it did at one point – it looked as if it was going to be an empty day. That is fine. So we are working on Monday being blank, the chances are we will finish the two witnesses today, so Friday is almost certainly a blank and Tuesday will be a 9.30 start.
We will have an indeterminate break at the moment. Thank you.

(The Committee adjourned for a short time)

(The Committee adjourned for lunch)

MR PEARCE: Sir, thank you. May I apologise that we start significantly later than I hoped we would be able to. Dr Thomas and Dr Dolben are both here. One of the reasons we have been delayed, for which I apologise, is that an issue has arisen about the medical records of patient A. The position, as I follow it, is this, that my learned friend seeks to see those records, not necessarily in order to cross-examine but seeks to see the records for that patient from the hospital, from the Trust. In December of last year the solicitors acting for Dr Cosgrove requested sight of those records. At that stage, those acting for the Council were seeking to obtain consent from the patient. Consent was not obtained, in the sense that there was no response from the patient, but it seems, to be frank with you, that both sides overlooked this point at the last hearing because the position in fact is not that dissimilar to what it was with patient A, in respect of which, of course, there was an abuse of process argument due to the non-availability or issues of consent relating to those records.

The way I put the matter to my learned friend today is this – I think he is content to proceed for the moment (he will speak for himself); I think he is content to proceed with the witness for the moment. What we will do in respect of this patient is to seek authorisation under the Medical Act which will permit us to obtain records without consent, and we will then provide them to my learned friend and, if necessary, seek to put them before the Committee – with, of course, the proviso, which you will recall from the last occasion that under Regulation 50 you might wish to indicate that you were happy to receive the documents notwithstanding the lack of consent. You will remember that this was an issue in respect of patient A last time.

I addressed you at length; I do not think there is any issue on the law here. I cited authorities on the last occasion that said that it was, in most cases, strongly in the public interest for your disciplinary Committee to proceed with this Inquiry rather than have, as it were, stay proceedings where consent is not available to have sight of the medical records. So I would repeat that for those reasons, in my submission, you ought to give an indication that you would happy to receive the records in evidence and, if so, we will seek that authority and seek to get those medical records just as soon as possible, and certainly we are hoping for Tuesday of next week. Some people tell me I am overly optimistic. If the records are not available next week then, of course, applications may follow from that or parties may have to take a different position. I think my learned friend is perfectly entitled to reserve his position as to whether, for example, it would constitute an abuse of process to continue with that charge if the records are not available.

THE CHAIRMAN: Thank you very much. I do recall that we actually referred to this issue in the determination in January, so I assume that that point was not picked up.

MR PEARCE: It was not picked up in respect of this patient. We dealt with patient A on precisely the same point. It was not picked up with patient F. I am told my learned friend would seek to see patient H’s records, which fall into exactly the same category as
patient F with the exception that in fact his instructing solicitors have never requested them from us, but we are in the same position – that we do not have consent – so, equally, if my learned friend seeks to see those records we will follow the same course of action in seeking to obtain those for next week.

THE CHAIRMAN: Mr Morris.

MR MORRIS: Sir, I am in virtual agreement with my learned friend. It was not an oversight on the part of the defence team not to include a submission in relation to patient F or, indeed, patient H on the last occasion because at that stage our understanding was that consent might have been granted or refused. I just quote from a letter from Field Fisher Waterhouse to those instructing me dated 8 January 2004, where they say in relation to patient F that they have written a chasing letter to the patient in relation to the issue of consent and, in relation to patient H, that they were awaiting a response to the request for consent. Obviously, had consent been formally refused I have no doubt I would have added those heads of charge in relation to the submission I made in relation to patient A.

THE CHAIRMAN: Thank you very much.

MR MORRIS: I confirm that I am happy that Dr Thomas gives evidence this afternoon but I reserve my position generally until receipt or otherwise of the notes.

THE CHAIRMAN: Thank you. Do the members of the Panel wish that these records be obtained? Yes. Legal Assessor?

THE LEGAL ASSESSOR: I do not think I have anything to add.

THE CHAIRMAN: We will proceed at the moment and hopefully the records will be available for the hearing early next week.

MR PEARCE: I am obliged, sir.

MELINDA REBECCA THOMAS, Affirmed

Examined by MR PEARCE

Q Could you give the Committee your full name, please?
A Miranda Rebecca Thomas.

Q Dr Thomas, are you a registered medical practitioner?
A Yes, I am.

Q Currently doing what?
A I am a GP retainer.

Q I think between August of the year 2000 and February 2001 as part of your GP training you were working as an SHO to Dr Chubb?
A Yes.
Q Is that correct?  
A Yes.

Q Where were you working?  
A I was working at Whitchurch Hospital and the Link Centre in Cardiff.

Q Could I then ask you to look at the bundle which is headed C8, which is to your right, and division 9 of that bundle?  
A Yes.

Q Is there, I think, a three-page letter dated 17 November 2000 to Dr Dolben – I think there is only one ‘e’; there is not one at the end. At any rate, to Dr Dolben, who I understand is a general practitioner from whom we will be hearing shortly, signed by Dr Cosgrove and copied to Dr Chubb and, I think, yourself. Is that correct?
A That is correct.

Q This makes reference to a patient and for the purpose of these proceedings we are using consecutive letters of the alphabet and this patient we are referring to is patient F. I think patient F was a patient on the list of Dr Dolben who you saw in October 2000, is that correct?
A Yes, that is right.

Q In what circumstances did you see patient F?
A He was referred to the community mental health team by his general practitioner requesting an assessment because he had been diagnosed with depression that, I think, was difficult to treat and also the patient had a concern that he might have adult Attention Deficit Hyperactivity Disorder.

Q So I think you saw patient F. Did you, during the course of the consultation, have a discussion with Dr Chubb?
A Yes.

Q Was Dr Chubb present during the consultation?
A No. I spoke to the patient, took the history, and then I went to discuss the case with Dr Chubb.

Q You then, some time after 17 November 2000, I take it, received a copy of this letter from Dr Cosgrove to Dr Dolben?
A Yes.

Q We see on the first page and a half or so that he deals with his consultation with patient F, his diagnosis, his prescription and suchlike. Can I take you then to halfway down page 232, starting “He has been seen twice by Dr Melinda Thomas”? I want to ask you to comment, if I may, on some of the things that are said in this letter. Taking that sentence I have just read:

“He has been seen twice by Dr Melinda Thomas, who works for Dr Helen Chubb, Consultant Psychiatrist.”
Is it correct that you twice saw patient F?
A No, I only saw him once.

Q Continuing:

“Between them, these two psychiatrists came to the conclusion that F has a Personality Disorder.”

Pausing there for a moment, did you come to the conclusion that F had a personality disorder?
A No. I did not come to that conclusion and I decided that we needed to see him again to decide what was wrong.

Q Did Dr Chubb come to that conclusion, to the best of your knowledge?
A No. She did not say to me that that is what she thought.

Q Did you tell patient F that there was no medication for a personality disorder?
A No, I did not talk to him about personality disorder at all.

Q Did Dr Chubb, to the best of your knowledge?
A No, she did not talk to the patient at all.

Q Continuing:

“He was told that referral would be made to a local psychiatrist who specialises in personality disorder.”

Was F to be referred to a different psychiatrist?
A No. After I had spoken to Dr Chubb, she said that we ought to find out some more about testing for ADHD in adults, so she suggested that we should contact one of the other psychiatrists who might know more about it to find out whether it was worth him being referred on to someone else and then to tell the patient that when we saw him again.

Q Going back to the letter:

“F did not feel that Dr Thomas listened to him when he talked about his personal understanding of ADHD.”

Let us break that down into parts. Did F talk about his understanding of ADHD?
A Yes.

Q Did you listen to him talking about ADHD?
A Yes, I did.

Q This is obviously a reference to you:

“She said that ‘a concentration problem is for messy kids’.”
Did you say that or something like it?
A I do not think I would have said anything like that. I think I was trying to have a discussion with the patient about what ADHD is and my understanding of it, and I think I would have explained to him that it was a problem that may be seen in children and one of the main features was that they were disruptive and lacked concentration. I did not say that it would necessarily be limited to that situation.

Q He goes on to say, a little further down in the same paragraph:

“It is ironic and, arguably, even medically negligent that F knows more about ADHD in adults than both these two psychiatrists combined!”

Putting aside the question about how much Dr Chubb knows about ADHD in adults or, indeed, how much F knows about ADHD in adults, could I just ask you in terms of how much you knew about ADHD in adults? Did you think your knowledge was commensurate with the post you were performing?
A I was not a specialist in psychiatry; I had heard about the possibility of ADHD but my understanding was it was disputed and it was a controversial issue to some extent, and it was not something that I knew an awful lot about, which is why I went to speak first to my consultant and then wanted to get some more information from someone with more expertise in the field.

Q I understand. Going on in the letter:

“Dr Thomas came back from telling Dr Chubb about F (for the latter has never seen him)”

- that corresponds with your recollection, I should say, that Dr Chubb did not see him?
A No, she did not.

Q Continuing:

“with a sentence of therapeutic nihilism to say, ‘The consultant thinks that you have got a Personality Disorder, which is not treatable.’”

I think you may have answered the questions already, but just so as I am clear. Did you say that the consultant thought he had got a personality disorder?
A No, I did not.

Q Did you say to F that that was not treatable?
A No, I did not.

Q Just reading through the next paragraph, if I may:

“If F responds to treatment for adult-type ADHD, it will show that he has got a treatable disorder. Since personality disorder is
untreatable, according to Drs Thomas & Chubb, it will mean that F does not have a personality disorder and that these two psychiatrists were wrong. It will also mean that F was right in his tentative diagnosis of ADHD in himself, and that they were negligent in not listening to him and in not knowing about ADHD as a real condition in adults. All this leaves room for a formal complaint to the Fitness to Practise Directorate of the GMC.”

Putting aside the question of the logic that Dr Cosgrove is perusing there, can I ask you this? Do you consider that you were negligent in your treatment of patient F on that occasion?

A No, I do not.

Q What was your response to receiving this letter, Dr Thomas?
A I was quite upset when I received it. I actually opened the letter and, having read it, I had to do a clinic, but afterwards went and showed it to Dr Chubb and discussed it with her. Then after that I did not do anything further in terms of any action on the letter, but when I saw the patient had another appointment with me a few weeks later I asked for one of my colleagues to come and sit in with me on the consultation in view of the letter that I had received.

Q Did that consultation go ahead?
A No, the patient did not arrive.

MR PEARCE: Thank you. If you wait there, Dr Thomas, Mr Morris, on behalf of Dr Cosgrove, will have some questions, I think.

MR MORRIS: Sir I do not have any questions of this witness. I am afraid I have to say that I may have some questions depending on receipt of the records. I have to reserve my position.

THE CHAIRMAN: There are no questions from the Panel. In the light of Mr Morris’s statement, that is the end of your evidence for today, Dr Thomas, but depending on the circumstances once the clinical notes are available it may be that we might have to recall you.

MR PEARCE: I think it might be appropriate if I just speak a little further to Dr Thomas about her availability next week. I have some idea about it, but it is not something I have had an opportunity to explore in detail. I know she is more readily available earlier in the week rather than later, but that may not necessarily fit very well with how we anticipate the week going. So I would welcome the opportunity to speak to her briefly about that. I am more than happy – I know we are having such a stop and start day in this case and I apologise again for that.

I believe that Dr Dolben, my other witness, will be very short - possibly significantly shorter that Dr Thomas, I think. It cannot be shorter than Mr Morris was but I think that I will be shorter with Dr Dolben than I was with Dr Thomas. If you prefer that we were to sit through and we will call Dr Dolben, deal with his evidence and then have a discussion with Dr Thomas?
THE CHAIRMAN: We will take Dr Dolben’s evidence.

MR PEARCE: I am much obliged, sir.

THE CHAIRMAN: You can now stand down from the witness stand. Thank you very much, Dr Thomas.

DR ROBERT DOLBEN Affirmed
Examined by MR PEARCE:

Q Could you give the Committee your full name, please?
A My name is Robert Dolben.

Q Just sticking there on the question of your name for the moment, it has managed to be spelt differently in different document.
A I know. It is a difficult name to spell.

Q My understanding is that the correct spelling is D-O-L-B-E-N?
A That is correct, yes.

Q I am obliged for that. Dr Dolben, I think that you are a registered medical practitioner with a general practice in Cardiff?
A That is correct.

Q Can I ask you to look at the bundle immediately under your arm, I think which should be headed C8 hand-written in the corner, which has a number of tabs and in particular under tab 9 there is, I think you will there see, a three page letter from Dr Cosgrove to you with your name misspelt, dated 17 November 2000. Is that correct?
A That is correct.

Q That letter refers to a patient who I think was a patient of yours. Is that so?
A That is right, yes.

Q For the purposes of the proceedings before the Committee, we are referring to patients by consecutive letters of the alphabet and this patient we are calling ‘F’, so that you are clear for anonymity purposes. In any event, could I just ask you about this letter. Having read this letter you will have noted, I think, that Dr Cosgrove - the bottom of page 231, the first page of the letter - considers that F has attention deficit hyperactivity disorder and he indicates, does he not, on page 232, that he was making out a private prescription for Ritalin?
A Yes.

Q “I will have a series of telephone appointments with him in order to monitor his progress and to find the optimum dosage and frequency through the day.”
Do you see that sentence?
A Yes.

Q Did Dr Cosgrove either in this letter or at any other time, ask you to carry out monitoring of either the condition of attention deficit hyperactivity disorder or the prescription that he was writing out?
A No, I cannot recall he did.

Q Could I ask you to look at page 233. The last proper paragraph of the letter:

“I have made out a specimen prescription for Ritalin but I know that he would very much appreciate it if you would copy it down on to an NHS scrip. On each occasion that I alter the dosage I will send him a fresh specimen prescription to bring to you.”

C Let me just understand what that means, particularly for those non-medical members of the Committee and, indeed, myself. Clearly there is a financial advantage to a patient if the prescription is issued under the NHS, or there may be a financial advantage?
A Yes.

Q I take that to be an invitation from Dr Cosgrove for you as a general practitioner to be issuing a prescription under the NHS in order to be of financial benefit to the patient?
A I assume that was the case, yes.

Q Had you issued a prescription, what responsibility would you have had, if any?
A Generally the prescriber of a drug retains responsibility for monitoring side effects, monitoring response of the drug. There may be cases where protocols may have been agreed with, for example, hospital consultants and under those circumstances where protocols are in place, then we are happy to prescribe drugs on behalf of a hospital consultant.

Q Was there any protocol in place between you, your practice and Dr Cosgrove?
A No.

Q Either generally or for this particular patient?
A No. This is the first time I had ever received any correspondence from Dr Cosgrove.

Q If you turn back a page to page 232, starting from half way down that page, there is a passage beginning, “He has been seen twice by Dr Melinda Thomas” and the a passage which relates to that consultation with Dr Thomas and to the conduct of Dr Thomas and Dr Chubb. I think it is fair to say that it, I think, is essentially admitted that it makes a number of criticisms of those two doctors. What was your response to receiving that letter and reading that passage?
A I was very surprised. As I said, it was the first time I had ever received correspondence from a consultant so openly criticising the practice of other physicians or psychiatrists. I was surprised particularly on the basis that this is the first time that Dr
Cosgrove had actually, I believe, met the patient in question and I do not believe that Dr Cosgrove had any real evidence or knowledge of the therapeutic relationship between the consultants in Cardiff and the patient in question.

Q I understand. Thank you very much, Dr Dolben. Mr Morris on behalf of Dr Cosgrove may ask you some questions.

MR MORRIS: I do not have any, sir.

THE CHAIRMAN: Are there any questions from the Panel? There being no questions, that concludes your evidence, Dr Dolben. Thank you very much for coming to assist us.

MR PEARCE: Thank you, sir. The position, then, now is as follows. I will speak to Dr Thomas about her availability next week. I think that is essentially a matter for me and my side and, to a certain extent, my learned friend’s side. I do not think we will need to invite any input from you.

The position otherwise is this. As I indicated before, I know have two remaining witnesses to give evidence orally - Patient D’s mother, or putative mother, who we will now call on Tuesday morning and Professor Taylor for the remainder of his evidence on Wednesday. We will seek to fit into that timescale a point at which Dr Thomas will be recalled if necessary, but you will immediately see the problem that if we do not know about the availability of the records until Tuesday, then we risk either getting her here on Tuesday and her not being asked any questions, or alternatively problems later in the week with timescales. We are acutely aware of the issue of completing this case next week, if that is at all possible. I assure you we will have that in the forefront of our minds.

In terms of timetable on Tuesday, my learned friend and I have discussed that at a little greater length this morning. You raised the issue of sitting slightly later on Tuesday. It appears to us, I think, speaking to each other, that from our point of view - or from my learned friend’s point of view - Mrs D will not be a long witness. His witnesses, I think, are arranged to attend at midday, if I recall.

MR MORRIS: They are arriving at about one, sir, to be ready for two o’clock.

MR PEARCE: I understand that Mrs D will not be in the witness box for the whole morning. It follows from that - and this is clearly a matter of convenience and it makes, I have to say, no difference to me but it may make a difference to the Committee and there may be cost and other benefits - to us starting a little later on Tuesday, if you wish to do so.

THE CHAIRMAN: Would 10.30 be a reasonable starting time?

MR PEARCE: I would think we are very confident that that will not affect the completing of the evidence.

THE CHAIRMAN: It gives two hours or so for Patient D’s mother and then the other witnesses can be taken in the afternoon. I am trying to make the best use possible of the
time available. I think if we go for a 10.30 start that should be adequate.

MR PEARCE: Yes, sir. I think that there is one remaining matter that, from my point of view, I would ask you to consider this afternoon, which is dealing with witness statements of two witnesses who I think I have mentioned previously where I indicated I would be applying to read those witness statements.

I am told by my learned friend that he is not in a position to consent to agree to that and therefore I take it that I have to make application to you to receive this evidence and we might conveniently, I think, as a starting point, look at what the rules have to say on this point. I have no doubt that you and your Committee have been referred before to Rule 50(1) of the Procedure Rules, if I can call them that.

"The Professional Conduct Committee may receive oral, documentary or other evidence of any fact or matter which appears to them relevant to the enquiry into the case before them provided that, where any fact or matter is tendered as evidence which would not be admissible as such if the proceedings were criminal proceedings in England, the Committee shall not receive it unless, after consultation with the Legal Assessor, they are satisfied that their duty of making due enquiry into the case before them makes its reception desirable."

The position here, sir, is that I am dealing with the statements of two witnesses who are unavailable to give evidence during the course of this hearing because of their absence on holiday. Those two witnesses, so that you can get some sense of the ambit of their evidence, are, first of all, Dr Helen Chubb, who is relevant to charge 9, the area of evidence with respect to which we have just heard from Dr Thomas and to a limited extent from Dr Dolben.

I do not want by the back door to introduce evidence that I do not have permission to introduce so can I just put it in, I hope, general terms in this way, that as you have already heard, Dr Chubb did not meet the patient and her evidence does not relate to any other dealings with Dr Cosgrove other than receipt of that letter that you have already looked at in respect of Dr Thomas. The purpose of her evidence, if I may say so, relates to the comments made in that letter and her response to those comments.

Can I make this clear sir, since this is sometimes relevant to consideration. In the event that you refuse permission for this evidence to be adduced before the Committee, I will contend and will be contending in my final submission in any event, that this head of charge is made out on the basis of other evidence, including the admissions of the doctor, so that, to put it another way, the charge does not stand or fall - in our submission it does not stand or fall - on the evidence of Dr Chubb and, if you refuse permission, it will not inevitably follow that I do not proceed with that evidence.

Sir, the second area or the second witness in respect of whom the same application is made, is Dr Dover. Dr Dover’s witness statement relates to head of charge 11 about which, other than my opening, you have heard nothing thus far.
It might again be convenient for you just to look at charge 11 and to see the ambit of that which is alleged by the GMC and that which has been admitted on behalf of Dr Cosgrove. You will recall that I read, I think in full, to some length at any extent, from a letter that appears at division 11 in the bundle and you will note, sir, that it has been admitted on behalf of Dr Cosgrove that he saw this patient, that he wrote to the general practitioner with a copy of the letter to H’s parents and to Dr Dover, that he admits that he made those three comments set out at (c) and that he admits at (d) (iii) that the comments were likely to cause the reader to doubt the knowledge or skills of Dr Dover.

The purpose of calling Dr Dover, sir, again without giving evidence through the back door, is to express his response to receiving that letter. Again, so that the position of the Council is clear, in the event that you were to refuse permission, we would say that that which is already admitted in respect of this charge potentially makes out the allegation of serious professional misconduct and furthermore, that that which is already admitted supports the contention that the doctor’s acts were unprofessional and unsustainable and therefore we would contend, even in the absence of the evidence from Dr Dover, that the charge is made out. Yet again, the charge does not stand or fall upon the evidence of Dr Dover being received by the Committee, in our submission.

Sir, the position we have taken, so that you are clear on what attempts have been made, as it were, to obtain these witnesses, notwithstanding their apparent unavailability, the view that has been taken on behalf of the General Medical Council, in my submission rightly, but it does not matter whether it is right or not, it is simply the view that was taken is that, given that this is an adjourned hearing when people have previously been making themselves available in any event, where witnesses had reasons not to be here we could not reasonably expect them to rearrange holidays and attend and therefore we took no steps further than establishing that they were not available before we took the view that we would only apply to read their evidence.

I trust, sir, that that assists the Committee in the background to how we come to make this application and the grounds upon which we seek your permission to receive the evidence.

THE CHAIRMAN: Thank you very much. Mr Morris.

MR MORRIS: Sir, obviously it is preferable for witnesses to attend unless their evidence is agreed and the reason for that preference is obvious. It enables the Defence to cross-examine those witnesses, which I may - and I can only say I may - wish to do so, depending on what if any notes I receive in relation to the particular patients with whom they had dealings either directly or indirectly.

I am, therefore, at a potential disadvantage if those witnesses are not available to give evidence and it is on that basis that I resist this application.

THE LEGAL ASSESSOR: If can just ask one question. Do you know where the witnesses are on holiday?

MR PEARCE: Yes.
THE LEGAL ASSESSOR: Are they outside the United Kingdom.

MR PEARCE: One in Corsica and one in France.

THE LEGAL ASSESSOR: I note that the terms of Rule 50 provide that:

“The Professional Conduct Committee may receive oral, documentary or other evidence of any fact or matter which appears to them to be relevant.”

I do not think there would be any argument here that their evidence is relevant, but there is a proviso that the evidence would have to be admissible in criminal proceedings in England.

Have either counsel addressed their minds to the question of whether their statement would be admissible under Section 23 of the Criminal Justice Act 1988?

MR MORRIS: Sir, I had rather assumed that because my learned friend was relying on Rule 50 he had conceded that the evidence was not admissible under the Criminal Justice Act because my reading of the proviso is that it applies in circumstances where the evidence is not admissible, or would not be admissible if proceedings were criminal proceedings, and the Council then has recourse to this Rule so as to allow the Committee to receive in evidence evidence which, if these were criminal proceedings, would not be admissible. As my learned friend only relied on Rule 50 I rather assumed---

MR PEARCE: There is a very good reason why I rely on Regulation 50 alone; if these were criminal proceedings I might well be able to rely on Section 23, that is true. Regulation 50 is clearly far broader than Section 23 in potential ambit and, therefore, it is I would say sufficient to say prima facie the evidence is inadmissible for it to come within the Regulation 50, power for you to admit it, then invite the Committee to exercise its discretion under Regulation 50. I appreciate there might be an argument that that might persuade a criminal court to do it, but I would be doing so under a narrower power than Section 23, with narrow requirements, rather than the broad requirements of Regulation 50.

THE CHAIRMAN: Could I just make an intervention. Would it be fair to say that looking at heads of charge 9 and 11 that the witness statements would really be addressing matters under 9d(i) and (ii) and 11d(i) and (ii) and these basically are matters for the panel rather than for witnesses?

MR PEARCE: It is a good point and it is another way of putting the point that I made earlier; that the charges do not stand or fall on the admission of the evidence. I accept there is some force in that point. Of course, you have to determine, or you may have to determine not only the factual basis but also whether it amounts to serious professional misconduct to have made comments of this nature. In that context what the doctor has to say about their involvement with the patient may be relevant. So it is not a position in which their evidence goes only to matters which lie purely within your domain. You are quite right to say that, it will be my submission in due course, that d(i) and (ii) are matters of influence for this Committee from the available background evidence, almost all of which is admitted in any event on behalf of the Doctor. But it does, in our submission, at
least potentially go to those issues you may need to consider of whether this amounts to serious professional misconduct.

THE LEGAL ASSESSOR: Just come back to the Rule 50 point. It seem to me that the proviso to Rule 50(1) applies to evidence which is not admissible in a criminal trial and I really want to ask: are you conceding that these statements could not be admissible in a criminal trial under section 23 of the Criminal Justice Act?

MR PEARCE: No, I am not.

THE LEGAL ASSESSOR: So if the evidence is relevant, and I must say that as far as I can see it is evidence which might bear on one of the issues in relation to one or other of the charges, if it is admissible under section 23 then you probably have a right to put it in evidence, hence my question whether or not these witnesses were overseas, which opens the door to the application of section 23. Do you follow my reasoning?

MR PEARCE: I do. If I may say so, I think it is perhaps a little bit more rigorous than the reasoning that I brought to bear in making the application. In principle I would argue that the status came within section 23(1) and I was simply approaching it from other way saying regular 50 is broader so we need do not need to consider Regulation 23(1).

THE LEGAL ASSESSOR: Could we have a look at section 23, because I think if section 23 renders these statements admissible then this Committee does not need to consider whether it exercises its discretion on the proviso.


THE LEGAL ASSESSOR: Written in remarkably opaque statutory language:

“The Criminal Justice Act 1998, ss 23, 24,

(1) Subject –
(a) to subsection (4) below; and

(b) to paragraph 1A of Schedule 2”,

of another statute,

“a statement made by a person in a document shall be admissible in criminal proceedings as evidence of any fact of which direct oral evidence by him would be admissible if -

(i) the requirements of one of the paragraphs of subsection (2) below are satisfied; or,
(ii) The requirements of subsection (3) below are satisfied.”

Going to subsection 2, that says:

“The requirements mentioned is subsection (1)(i) above are -
(a) that the person who made the statement is dead or by reason of his bodily or mental condition is unfit to attend as a witness;

(b) that –

(i) the person who made the statement is outside the United Kingdom; and

(i) it is not reasonably practicable to secure his attendance; or.”

So I think on the question of whether this statement is admissible, if the witness is outside the United Kingdom, that is the first test, second, it is not reasonably practicable to secure his attendance. The question which has to be answered there is: is it reasonably practicable to secure his attendance now and presumably the answer to that must be no?

MR PEARCE: Clearly we would say no, sir, out of the very fact the person is abroad on holiday.

THE LEGAL ASSESSOR: My advice is that prima facie section 23 applies. If that is the case the statement is admissible, there is no need to go to the proviso of Rule 50. The only thing I ought to do is ask Mr Morris what he has to say about the admissibility of that statement under section 23?

MR MORRIS: Sir, these dates were fixed back in January and no doubt witnesses would have been, or should have been told about the dates and, in my submission, the issue of practicability, therefore, has to be seen not merely from the point of view of looking now when they are present in France, but from an earlier perspective.

If, however, it is thought that it impracticable for them to attend, then certainly the provisions of section 23 are met. One then has to proceed to apply the principles set out in section 25 which state that:

“If, having regard to all the circumstances –

(a) the Crown Court -

(i) on a trial on indictment;

is of the opinion that in the interests of justice a statement which is admissible by virtue of section 23 or 24 above nevertheless ought not to be admitted, it may direct that the statement shall not be admitted.”

So admission of the evidence is not automatic following on satisfying Section 23 and the various considerations that have to be borne in mind by the Committee are then set out in 25(2):

“Without prejudice to the generality of subsection (1) above, it shall be the duty of the court to have regard –

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(a) to the nature and source of the document containing the statement”,
and its authenticity. I do not seek to dispute that,
“(b) to the extent to which the statement appears to supply evidence which
would otherwise not be readily available.”

My learned friend has conceded in relation to both these witnesses that other evidence is
available in relation to the issue which they address:
“(c) to the relevance of the evidence that it appears to supply to any issue
which is likely to have to be determined in the proceedings”,

That clearly is relevant:
“and,
(d) to any risk, having regard in particular to whether it is likely to be
possible to controvert the statement if the person making it does not attend
to give oral evidence in the proceedings, that its omission or exclusion will
result in unfairness to the accused or, if there is more than one, to any of
them.”

So that perhaps is a reference to the point the Chairman made about to what issue and
whether their evidence is of any assistance on the unproved allegations made in 9d(i) and
(ii) and 11d(i) and (ii).

In my submission, their evidence may go to those issues because, for example, if they
were to concede that, for example, if one looks at Dr Dover at 11c(ii), if he were to
concede in evidence that he should have studied Patient H’s school reports, then to make
that comment, or that evidence would go to the question or whether or not that was a
sustainable comment.

So the matter does not end with the satisfaction of section 23, one has to consider the
matters in section 25.

THE LEGAL ASSESSOR: Thank you. Just come back to you, Mr Pearce, section 23, the
requirement that it is not reasonably practicable to secure his attendance. Do you know
of any authority at which point you have to consider whether it is reasonable practicable
to secure his attendance? Whilst I said originally it was not clearly reasonably
practicable to secure his attendance now, it would certainly be, would it not, reasonably
practicable to have secured his attendance by a subpoena in the the weeks proceedings.

MR PEARCE: It would have been practicable, whether it was reasonably practicable
might be where we take issue. I am not seeking to argue that you have to make the
decision now, we can wait until the moment of calling and the person say there is nothing
we can do about this because they are effectively -- one might say if they were ten miles
away I would not be reasonably practicable. I do not seek to argument argue it that way.
What I do seek to argue is in the context of this case as an adjourned hearing it was not
reasonably practicable to secure their attendance once we knew, as we did, when we approached them to attend this hearing that they were not available. Just to flesh out. Yes, this hearing was fixed in January of this year, we know the circumstances in which the date were canvassed. We certainly did not seek to check availability of witnesses then because, frankly, the view we took was the case had to be fixed for a hearing when this Committee and these lawyers could attend. That was the priority and fitting witnesses in,

I am afraid, in the context of the case, case was somewhat secondary to that and was not going to determine whether any particular (Inaudible). So I defend, if I put it that way, the approach to fixing the case, then seeing whether the witnesses were available, in terms of reasonably practicability, as I indicate, that arises we would say from the fact of the context of an adjourned hearing where the witnesses have been asked to attend before, it was not then reasonably practicable to cancel all arranged holiday in order to be here.

THE LEGAL ASSESSOR: Is it a question of law, the reasonableness, or a question of fact?

MR PEARCE: Question of fact, I would say.

THE LEGAL ASSESSOR: Mr Morris, do you agree?

MR MORRIS: I do.

THE LEGAL ASSESSOR: Thank you very much. I am helped by that. I think I can take this quite quickly. My advice to you is that the evidence of Dr Chubb and Dr Dover is potentially relevant to the question to be decided in the charges to which, shall we say, their evidence relates. Their reaction to certain letters that were written by Dr Cosgrove is, in my opinion, relevant and on that basis I advise you.

The next question to be addressed is: is their evidence admissible within the meaning of the Criminal Justice Act 1988, section 23? The decision that has to be made there, because I think it is not disputed they are outside the United Kingdom, is whether or not it is reasonably practicable to secure his attendance. The way we approach that, I advise you, is not to restrict yourself to is it reasonably practicable now to get him, but whether it has been reasonably practicable to secure his attendance in the normal course of the preparation of this case. If you decide – and I think that is properly a question of fact for you to decide on what you have heard from both counsel - if you decide that it has not been reasonably practicable to secure his attendance, then section 23 of the Criminal Justice Act 1988 will apply, the statements will then be admissible per the basic principle, and in which case then you can receive them, provided you then go on to consider the matters which Mr Morris has referred to in section 25 of the Criminal Justice Act which directs you to take into account certain matters in deciding whether you exercise your discretion to so admit the documents.

If, on the other hand, you decide that it has been reasonably practicable to secure the attendance of the witness my advice to you is that the statements are inadmissible from the point of view of a criminal court, in which case then the proviso applies to Rule 50(1), which reads as follows:

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“Provided that any factual matter is tendered as evidence which would not be admissible if such proceedings were criminal proceedings”,

I pause there to say that you have to make an antecedent decision admissible in criminal proceedings in England. Carrying on with the quotation:

“...the Committee shall not receive it unless, after consultation with the legal assessor”

(which it has done)

“they are satisfied that their duty of making due inquiry into the case before them makes its reception desirable.”

So if you reach the point that the evidence is inadmissible as per the rules of evidence which I have described to you, you then have to consider if you are going to make a due inquiry into this case is the reception of that evidence desirable. That is very close to the question, in many ways, of whether or not the evidence is in itself relevant to the charges. It will then be a question of fact whether or not you consider that evidence is such that it crosses the line from being relevant to being desirable; its reception being desirable.

I do not think I can elaborate on the words “desirable” or “relevant”. They are the English words used in the relevant rule and it is a question of fact for you to decide that.

Do either counsel have any observations on the way in which I have set out the reasoning that I think the Committee should follow?

MR PEARCE: No.

MR MORRIS: No.

THE CHAIRMAN: May I just ask, is there any information as to when these witnesses were notified as to the dates of the current hearing?

MR PEARCE: I thin the answer to that is yes, but I will just check. (Pause) The answer is we may be able to obtain the information but we will have to go and search it out.

THE CHAIRMAN: What is the date of the witness statements?

MR PEARCE: Dr Chubb is 11 July 2003, Dr Dover 29 September 2003. Of course, they were both prepared for the previous hearing.

THE CHAIRMAN: Fine. We will now go into private session to consider this question.

PARTIES THEN, BY DIRECTION FROM THE CHAIR, WITHDREW AND THE COMMITTEE DELIBERATED IN CAMERA

PARTIES HAVING BEEN READMITTED
THE CHAIRMAN: Mr Pearce, the Committee has carefully considered your application for the Committee to receive the witness statements made by Dr Chubb and Dr Dover. You have indicated to the Committee that those statements are relevant to Heads 9 and 11 respectively.

The Committee has considered the submissions made by Mr Morris acting on behalf of Dr Cosgrove. Mr Morris has submitted that it is preferable for the witnesses to give evidence before Committee to allow for cross-examination. Mr Morris has indicated that there is a potential disadvantage in not having the opportunity to cross-examine this evidence.

The Committee has had regard to Rule 50(1) of the Committee Procedure Rules and sections 23 and 25 of the Criminal Justice Act 1988 in respect of the receipt of this evidence and has been guided by the advice of the Legal Assessor.

The Committee finds that the requirements of section 23(2)(b) of the Criminal Justice Act 1988, that it is not reasonably practicable to secure the witnesses attendance, have not been met. Nonetheless the Committee considers that the information contained within the statements may be relevant to their inquiry. It has therefore decided under the proviso to Rule 50(1) of the Committee's Procedure Rules that it is desirable and in the interests of justice, bearing in mind the question of fairness to both the parties involved and Dr Cosgrove, that the statements should be received.

The Committee will be able to afford appropriate weight to the documents' relevance and validity in due course.

MR PEARCE: I am obliged, sir. Then if it is a convenient point to read those two statements, I do so, sir.

The first statement is of Helen Chubb MB BCh MRCPsych MRCGP:

“I am employed as a Consultant Psychiatrist by Cardiff and Vale NHS Trust at the Link Centre, Langcross Street, Cardiff.

Between August 2000 and February 2001 Dr Miranda Thomas was my S.H.O. On 24 November 2000 Dr Thomas received a letter from Dr P V F Cosgrove which was addressed to Dr Dolbenn dealing with a patient whose identity I know and will refer to as F. I have been shown a copy of this letter, Exhibit RD1, and I identify this as the letter.

The letter contained references to Dr Thomas and myself and in particular to Dr Thomas' dealings with the patient F. I found the letter extremely offensive and felt it could be even libellous towards Dr Thomas and myself. The content was grossly inaccurate and where Dr Cosgrove had put phrases in quotes that he claimed Dr Thomas made these were most definitely inaccurate.
Dr Cosgrove alleged Dr Thomas has seen F on two occasions which was untrue and that she and I had come to the conclusion that the patient had a personality disorder and there was no medication to treat it.

Dr Thomas only saw F on one occasion and after this consultation her diagnosis of him was unclear and no conclusion had been made.

The letter alleged that Dr Thomas had told F that ‘the consultant thinks that you have got a personality disorder which is not treatable’. Whilst I was not present when Dr Thomas is alleged to have stated this to F I cannot believe that it was said and I certainly did not say it to Dr Thomas during the discussion I had with her about this patient.

It is possible to suffer from ADHD and a personality disorder and Dr Cosgrove's statement in the last paragraph of page 2 of his letter that ‘if F responds to treatment for adult type ADHD, it will show that he has got a treatable disorder. Since personality disorder is untreatable, according to Dr Thomas and Chubb, it will mean that F does not have a personality disorder and that these two psychiatrists were wrong’. I felt this statement was made to bring Dr Thomas and my professional into disrepute and was extremely disturbed that Dr Cosgrove went on to suggest that the patient make a formal complaint about us to the General Medical Council.

I understand that my statement may be used in evidence for the purposes of a hearing before the General Medical Council's Professional Conduct Committee. I confirm that I am willing to attend the hearing to give evidence if asked to do so.

I believe that the facts stated in this witness statement are true.”

Sir, the other statement is that of Stephen Dover:

“I, Stephen Dover, will say as follows:

I am a Consultant in Child and Adolescent Psychiatry employed by North Staffordshire Combined Healthcare NHS Trust at the Mental Health Directorate, Child and Adolescent Mental Health Service, Ripon Road, Blurton, Stoke on Trent.

On 16 July 2003 Dr Cosgrove carried out a private assessment of a patient whose identity I know and will refer to as H, who was previously under my care. Dr Cosgrove diagnosed H. as suffering from Attention Deficit Hyperactivity Disorder (ADHD). On the 19 July 2003 Dr Cosgrove wrote a letter to H's General Practitioner a copy of which was also sent to H's parents and myself. I produce
a copy of this letter.

I was very concerned about this letter as a large part of the content was highly critical of my practice with Dr Cosgrove's conclusions being based on information provided to him by H's parents that actually had no basis in fact.

In particular my team has had ongoing involvement with H over a number of years and have liaised extensively with various educational professionals about his progress. In addition at no time has his General Practitioner actually asked me to arrange a second opinion.

Dr Cosgrove's comments in this letter about my revalidation with the General Medical Council are in my opinion particularly unacceptable. Unfortunately he made no effort to contact me prior to writing this letter to ascertain whether what he was writing was actually true.

I am concerned that unfounded criticism of my practice has been shared with a local General Practitioner with whom I will have to continue to work around other cases. More seriously, Dr Cosgrove has also copied his letter directly to H's parents and I have since been contacted by the father of H who has informed me that following Dr Cosgrove's comments about my practice he was considering contacting a solicitor.

Overall I am extremely concerned about Dr Cosgrove actions which in my opinion would seem quite inappropriate.

I understand that my statement may be used in evidence for the purposes of a hearing before the General Medical Council's Professional Conduct Committee. I confirm that I am willing to attend the hearing to give evidence if asked to do so.

The contents of this statement are true to the best of my knowledge and belief."

That concludes the second of those two statements.

THE CHAIRMAN: That concludes the business for the week and we will reconvene at 9.30 on Tuesday. Thank you.

(The Committee adjourned until Tuesday, 15 June 2004)
GENERAL MEDICAL COUNCIL

PROFESSIONAL CONDUCT COMMITTEE

On:

Tuesday 15 June 2004

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

Case of:

PATRICK VERNON FINN COSGROVE MB BS 1968 Lond
(Day Eight)

Committee Members:
Professor N Mackay (Chairman)
Dr A Hamilton
Mr J Matharu
Dr B Stanley
Mr R Briden (Legal Assessor)

MR D MORRIS, of Counsel, instructed by Messrs RadcliffesLeBrasseur, appeared on behalf of Dr Cosgrove, who was not present.

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

(Transcript of the shorthand notes of Transcribe UK
Tel No: 0208 614 5799)
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THE CHAIRMAN: Good morning, Mr Pearce.

MR PEARCE: Thank you. I call my next witness, Mrs D.

MRS D, sworn
Examined by MR PEARCE

Q You will recall from when you gave evidence before that we are calling you Mrs D and your son D for the purposes of this hearing.
A Yes.

Q Mrs D, could I ask you, first of all, to write on that blank piece of paper before you your name, your address and your son’s name, please. (Pause.) (Same handed.) Sir, I do not know whether that needs to be given a formal exhibit number. It probably ought to be.

THE CHAIRMAN: C14.

MR PEARCE: I am much obliged. (To the witness): Mrs D, when was your son born? What was his date of birth?
A 12 February 1986.

Q When he was a baby did you have any difficulties with his behaviour?
A As a baby D never slept and was very difficult to feed. This went on for quite a number of years and when he reached the toddler years I had been to see a GP beforehand but it was just the new baby syndrome and “This is your first child”, you know, “it will come to you”. When he reached the twos it was not getting any better and it was then again the terrible twos. He was not eating, he was not sleeping but it just continued and continued along those lines.

Q Did he start at a nursery school eventually?
A Yes, he went to nursery school when he was about four years old.

Q Was any referral made in respect of his behaviour?
A Yes, the nursery nurses approached myself and said that D was very active to the point that he was annoying the other children in the nursery and had words to me that he had ants in his pants and could not sit in peace and possibly I would be best to go and see a child psychologist because D’s Dad and I had separated at that point and they felt that his behaviour could have been part of the disruption in his life.

Q So what was the view taken by the psychologist as to what you ought to do about D’s behaviour?
A Be firm with him, just say no, you know, tell him what to do and do not back down against it, but it did not matter what I tried to tell him to do, he just constantly fought against it.

Q Did this problem continue when he was at school?
A Yes.
Q How did the school manage his behaviour?
A Well, they did not to such an extent that D was removed from class rooms. He was stopped from playing at play time and at lunch time I had to take him home. He was just put outside the classroom to sit at a table on his own with a school auxiliary to be taught on his own.

Q I think there came a point when you found about ADHD, Attention Deficit Hyperactivity Disorder. How did you find out about that condition?
A It was through a television programme.

Q As a result of watching the television programme did you send off for a fact sheet?
A Yes.

Q Did you read a book on the subject?
A Yes.

Q Is it right that you spoke to somebody in a family support group?
A Yes.

Q Did she suggest that you contact Dr Cosgrove?
A Yes, that is right.

Q Did you then arrange an appointment to see Dr Cosgrove?
A Yes, I did.

Q When did you go to see the doctor?
A D was about 10 ½ when we went to see Dr Cosgrove, so it would be 1996.

Q Yes, that would put it in the middle of 1996.
A Yes.

Q I think we know you live in Scotland.
A Yes.

Q Where did you travel to to see the doctor?
A The Bristol Priority Clinic.

Q When you attended on Dr Cosgrove was it there and back in a day?
A Yes. I was like in and out seeing Dr Cosgrove within half an hour.

Q During your consultation with Dr Cosgrove what enquiries/investigations did he make?
A What I took down with me were school reports about D’s behaviour and what the school were trying to do to contain his behaviour within class. I gave that to Dr Cosgrove. Dr Cosgrove in turn gave me a tick questionnaire type where there was about 20 questions in a box and you need to tick each box that was relevant to D’s behaviour and once I had completed that I handed it back over to Dr Cosgrove and Dr Cosgrove concluded that D had ADHD, hyperactivity.
Q Did Dr Cosgrove suggest that anything could be done to assist with your son’s condition?
A Yes. Dr Cosgrove suggested that D be put on Ritalin and said to me that that would more or less take away all of D’s problems relating to his hyperactivity and not being able to sit and focus in school.

Q During the course of the consultation did Dr Cosgrove ask you any questions?
A Yes, he asked me some short questions like when D was born, how was he when he was a baby, did he sleep, did he eat, not much more questions than that.

Q Did he ask your son any questions?
A No, he did not even acknowledge that D was there.

Q What was your son’s behaviour during this consultation?
A It was quite a small room we were in and Dr Cosgrove had a desk. I sat in the chair next to the desk and there was a couch and another chair directly behind and D was jumping over the furniture and all Dr Cosgrove said to him was, “Could you please stop jumping on the furniture, it does not belong to me”.

Q Did Dr Cosgrove examine your son in any way?
A No, he did not.

Q How much did you pay for the consultation?
A £160.

Q What, if any, arrangement was there about contact between Dr Cosgrove and you after the consultation?
A Dr Cosgrove arranged telephone contact two weeks after the initial appointment at the cost of £25 a telephone consultation.

Q Did you understand that that would be the only telephone consultation or did you know whether Dr Cosgrove wished there to be further consultations after that?
A It was not clarified. I really was not too sure how often or how long these telephone consultations would need to go on.

Q Was any arrangement made about you returning to see Dr Cosgrove?
A No. When I made the initial appointment I took it to be his secretary but I do not know who the female was that I spoke to over the phone had said should I require to attend a second time it would be a reduced fee of like £80. That was all I was told.

Q Were you in fact required to attend a second time?
A No, I did not go back a second time.

Q Did you ever see Dr Cosgrove again for a consultation?
A No, I did not.

Q Let me ask you about telephone consultations, if I may. After that consultation at the clinic did your son then start to take Ritalin as prescribed?
A
Q Did Dr Cosgrove have contact with you by telephone?
A Two weeks after the initial consultation he did.

Q What did you say in the course of that conversation about your son’s behaviour?
A I was concerned. I did see a slight change in D’s behaviour when he took the medication, but the more concerning bit about it was that D was tending not to eat and not to sleep, he was going all day without having any food and come bed time he was not able to relax and go to sleep.

Q Just so we understand, so you did see some change in his behaviour.
A Yes.

Q For the better or for the worse?
A He did calm down, yes.

Q He did calm down?
A Yes.

Q Calm down completely?
A No.

Q Was it to a level you would call normal?
A No, it was not normal, but it was containable as to the fact that it was not before.

Q After you had told Dr Cosgrove this what, if any, arrangements were made about continuing medication?
A Dr Cosgrove, because I was concerned about D’s weight loss and not being able to sleep, suggested a second line drug and in his own words it would solve all the problems that Ritalin was giving D and more or less it would help him to eat, it would help him to sleep, it would take away all the side effects and his words to me over the phone were that I would not need to see another doctor regarding D’s behaviour, because the next set of tablets would stop that from happening.

Q So there was a sleeping tablet. Did your son start to take a sleeping tablet?
A It was a drug called Risperidone.

Q What about the Ritalin, did that continue?
A That continued.

Q At the same dose?
A Yes.

Q The same dose?
A The same dose and then it would go up after the first three days. It started off at half a tablet, then it would go up to one until D was on a maximum dose of six a day.

Q Those tablets, was it obvious to you from the medication bottle or from what Dr
Cosgrove said as to what the dosage was of those tablets?
A    The dosage that Dr Cosgrove had written down and noted on a piece of paper initially for me to take home. He had given me the prescription for Ritalin there and then, the dosage was marked on a piece of paper and after the telephone conversation he told me to increase the dose to whatever it was. With the second drug Dr Cosgrove just sent me out a private prescription through the post and I had to go to the chemist to get it.

Q    So that was the first telephone consultation with Dr Cosgrove.
A    Yes.

Q    Was there a further ----- 
A    There was two, a second one, there was two telephone consultations.

Q    Two telephone consultations.
A    Yes.

Q    When was that?
A    Two weeks after the first one.

Q    So about a month after the original attendance at the clinic. 
A    Yes.

Q    What did you have to say to Dr Cosgrove then about your son’s progress?
A    What I said to him was that I was pleased that D was starting to eat and he was starting to sleep and so far things were all right, kind of thing.

Q    What was done about dosage or drugs then?
A    Dr Cosgrove had just told me to take what he had written down on the piece of paper and the letter that he had sent out along with the prescription, to continue to take the same dose.

Q    I think you have indicated that there was a relatively low dose at the start and it had increased to six tablets.
A    Yes.

Q    And six tablets was the maximum dose that he was prescribed.
A    Yes.

Q    How long after starting on Ritalin did your son reach that dosage?
A    It could possibly have been about six to eight months that he could have gone up to 60 milligrams of Ritalin.

Q    So I am clear, how many times did you speak to Dr Cosgrove on the telephone?
A    Two telephone conversations.

Q    Did there come a time when it is obvious from what you are saying, that the prescriptions for Ritalin carried on? Who then was prescribing the Ritalin?
A    It was my own GP.
Q Did there come a time when you changed your GP?
A I had initially when I stayed at my first address when I went to see Dr Cosgrove the first time, I had a different GP at that point, and then my partner and I split up and I moved home so I then got another GP who originally was my own GP from when I was a girl and I moved back into that catchment area.

Q So you had returned to that area.
A Yes.

Q What was that GP’s name?
A Dr Spence. Dr John Spence.

Q Did Dr Spence continue the prescriptions of Ritalin?
A Yes, he did.

Q And Risperidone or not?
A Yes.

Q For how long did your son take those drugs?
A Roughly about three-and-a-half years.

Q How did it come about that he stopped taking them?
A I was getting a bit concerned about D’s behaviour. The drug did not seem to be working as well as I thought it should have worked and he was in his last year of primary when the school contacted me again to say that D was being disruptive and could not continue in class and they were really quite concerned for him going to secondary school, so that is when I contacted my GP again and my GP just did not know what to do because he was not an expert of any of the medication that was given out. He did not now much about ADHD, so he decided to refer me to Dr Sarah Hukin, who was an adolescent child psychologist.

Q Let us get that name again. Sarah Hukin. Is that right?
A Yes, Sarah Hukin.

Q Is ‘Hukin’ H-U-K-I-N?
A Yes.

Q And a child and adolescent psychologist, did you say?
A Yes. Psychiatrist, sorry.

Q What treatment did Dr Hukin prescribe?
A Dr Hukin decided to take D off Risperidone and introduced another drug similar to Risperidone called clonidine. She started off with a low dose of clonidine for D and eventually that was to work up to whatever level she decided and she said to me it was a very dangerous drug, it should not be stopped immediately because it can cause seizure, heart attack, as far as I know. D’s behaviour was still as erratic as it was before and I did not see any benefit from being on the clonidine and I wanted him taken off the clonidine.

Q You wanted him to come off the clonidine. Was he still on the Ritalin at this
Q: How did it come about that he ceased taking drugs?
A: I had read an article in the newspaper, in one of the local papers and it was about a support group in Edinburgh called Overload and Janice Hill, the woman that had written the article, had gone through an awful lot with her own daughter, behavioural problems and she was writing about Ritalin and how freely available it was on the streets.

I then contacted Janice Hill and had spoken to her and she had raised some fears that I already had about the drug and I made an appointment to go and see Janice Hill in Edinburgh and had spoken through a lot of things with Janice. I decided then at that point that Ritalin was not doing D any good - none of the drugs were because his behaviour was just going back to the way it was.

Q: So you, having investigated this matter, you felt that it was inappropriate for your son to continue taking these drugs?
A: Yes.

Q: Then did you speak to doctors about that?
A: Yes. I spoke to Sarah Hukin about it and she more or less said, “Well, Mrs D, it is your choice if you wish to take your son off these drugs and want to go down another avenue.” I was going to go down the avenue of vitamin tablets and stuff like that, with the Overload network. I was going to see a Professor Steve Baldwin. My son saw Steve Baldwin once before he was killed in a train crash.

Q: That is to say Dr Baldwin, not your son, was killed in a train crash?
A: Yes.

Q: Sorry, just so we are clear.
A: My son saw him once and he was unfortunately killed in a train crash, so after that I was kind of left to my own devices to try and work things out because there were no other services available.

Q: In any event, your son came off those drugs?
A: Yes.

Q: Could I ask you to look at one document that I think you may have been asked to look at before when you gave evidence which is not in the bundle. It is one of the exhibits, D1, which is one of the exhibits produced on the last occasion.

MR MORRIS: If it is of any assistance I have had copied D1 in case the Committee did not retain it.

THE CHAIRMAN: That would be helpful because the Secretariat has retained only one copy. The Panel members will be without. (Copies produced)

MR PEARCE: Mrs D, is this a letter you wrote to Dr Cosgrove dated 23 September 1996?
A

Yes.

Q I will just read it through quickly so that we can refamiliarise ourselves with it:

“I am writing to you to apologise for the delay in sending your fee of £54.00. I have recently moved house and changed my doctor so things are a bit hectic at the moment. D is doing very well with both drugs, Ritalin and Risperdal (sic). My new doctor, who’s name is Dr Spence, Gilbertfield Street, Ruchazie, Glasgow, is very helpful and has no objections to prescribing the drugs. I am not on the telephone yet but hope to be in the near future. I wish again to thank you so very much for your help. If it had not been for you I think D would probably be in care. I do not want to break contact with you and I will send your money as soon as possible.”

Old and new addresses are given.

“Thank you again so very much and I hope to be able to speak to you soon. Kind regards.”

It is apparent from the tone of that letter that at that stage you were appreciative of Dr Cosgrove’s efforts to assist your son?

A Yes, that is right.

MR PEARCE: Thank you. I have no further questions at the moment. Mr Morris may have some.

Cross-examined by MR MORRIS:

Q Mrs D, 1996 was a long time ago. Would you accept that your recollection now of events then perhaps is not entirely perfect?

A It depends on what you are putting forward to me. I could not possibly answer that question.

Q For example, you suggested that you had two telephone conversations with Dr Cosgrove. I suggest it was three?

A No, it was two.

Q Are you sure about that?

A Yes.

Q You talked about a maximum dosage of six tablets?

A Yes.

Q Of Ritalin a day. Who prescribed that dosage?

A Dr Spence.
Q Do you recall the dosage that Dr Cosgrove recommended for your son?
A Initially it started off at half a tablet to one tablet to possibly three tablets a day.

Q I would like to see what you have to say about some of the documents that were created at the time in 1996 and whether or not you accept what was put in them. I wonder if you could have with you a copy of C8, which you may have. You will need to turn up tab 6. You have got D1. I would like you to have before you a bundle of records from D’s, your son’s, general practice records, together with one document from the psychiatric records.

THE CHAIRMAN: This will be D30.

MR MORRIS: The final document is a chronology headed, “Patient D Chronology”.

THE CHAIRMAN: This will be D31.

MR MORRIS: Mrs D, can I explain that that chronology is not an original document. It has been created by me collating notes taken from your son’s records and if I have got it wrong, no doubt you will correct me as we work our way through it. Could I just assist you and members of the Committee with the bundle D30. There is pagination, although there is an omission on the second page. It is the second page of a letter from Dr Steer, consultant paediatrician, to Dr Spence. That did not appear in the copy document that I had, so perhaps it could be called 140A. Apart from that hiatus, the pagination continues in order until we get to the penultimate three pages, when you will see the pagination reverts backwards to 119 to 121, that is notes of an external case conference.

The explanation for that is that they are taken from a bundle of psychiatric notes, whereas the remainder of the notes are taken from the GP records.

Mrs D, can I take you back in time, then, to before you heard about Dr Cosgrove, back to early 1996 and to the notes of a case conference that was held and conducted or chaired by Dr Joanne Barton. You will see that at pages 119 to 121, at the very back of that bundle D30. Do you see that? Headed, “Not to be circulated without the consent of the author”?

A Sorry, what page was that?

Q 119 to 121. Right at the very back.

THE CHAIRMAN: The witness is confused. It is the bundle that starts with the heading, “Paediatric Department, Kirkcaldy Acute Hospitals” and it is the last three sheets in the bundle. Have you got it?
A I have got it, thank you.

MR MORRIS: Is this right, Mrs D, that your son had been seen by another consultant psychiatrist, Dr Robinson, and she had diagnosed a conduct disorder?
A Yes.

Q You were not happy about that diagnosis and asked for a second opinion?
A

A       That is right.

Q       And you received that second opinion from Dr Barton?
A       Yes, that is correct.

Q       And before that second opinion was given, Dr Barton recommended that your son come in for some inpatient assessment?
A       Yes.

Q       I think what we have there is the Case Conference that was conducted after that inpatient assessment and I believe you specifically asked to see these notes, do you recall that?
A       No, I have never seen these notes. This is the first time I have seen them.

Q       Right. Can I just take you to the second page of that document under the heading "Family Work", do you see that?
A       Yes.

Q       Now, in the third line the author says:

"It is very clear from the discussions with Mrs D that the major issue for the family concerning D is the nature of the diagnosis".

I am sorry, perhaps I ought to give the date of this which is 3 April 1996:

"... the major issue is the nature of the diagnosis and, therefore, the nature of the treatment that the diagnosis will elicit. Mrs D does not accept that the diagnosis provided by Dr Robinson and Dr Barton of mixed disorder of emotion and conduct is correct and feels very strongly that the diagnosis fits the description of Attention Deficit Disorder, as described by Dr Chris Green. Mrs D has also been involved in discussions with the local ADHD Support Group. Therefore, mother is very keen for D to be tried on a course of Ritalin to see whether this alleviates some of the difficulties she is clearly experiencing at home. It is clear that Mrs D feels she is not getting the help she needs from the Department of Child and Family Psychiatry and what has been offered so far is not seen as appropriate".

Is that an accurate account of what you were thinking at the time?
A       Yes.

Q       I think it goes on to say:

"Mrs D did indicate that she would be willing to work with a joint package of help for the management of D if it did include the use of Methylphenidate",

which as you probably know is Ritalin?
A       Yes.

Q       It is right, is it not, that I think Dr Barton was not prepared to go down that route and agreed effectively with Dr Robinson's diagnosis?
A       Yes, that is correct.

B       And she says over the page on 121:

"It is difficult to see how the present situation can be moved on with respect to the family's contact with the Department until there is agreement or consensus on the diagnosis and treatment thereof. It is clear that, if the Department do not provide something acceptable to Mrs D, she will continue to be active in seeking out other agencies who may provide a diagnosis and treatment that is more acceptable to her".

And they go on to say, the authors, that the diagnosis is confirmed, namely that of mixed disorder of conduct and emotion, and:

"It was felt that the treatment model should again be carried out on an out patient basis by the local community psychiatric team. The In Patient Team will urge Mrs D to reconsider the help offered by Dr Jean Robinson, particularly on an individual basis for D, as he is clearly very confused and unhappy, which is very much affecting his relationship with his family ... ",

and they effectively discharged your son on 4 April, with a recommendation to continue involvement with the local team, and I think you said that you had a meeting with the Ward Manager to let you know what they were thinking?

A       Yes.

Q       And just as confirmation of Dr Barton's view, if we look at the GP records, 174 to 175, a letter from Dr Barton to your GP Practice I think, Dr McColl, dated 7 May 1996. I do not know whether you have found that?
A       Yes.

Q       When I think she confirms her view that she agreed with Dr Robinson in relation to the diagnosis and says in the third paragraph:

"It is my feeling that Mr and Mrs D continue to have difficulty accepting this diagnosis, feeling that D's primary problem is one of Attention Deficit Disorder and that he requires treatment with Ritalin ... Mr and Mrs D, however, are, I understand, intent on pursuing a referral to Dr Cosgrove in Bristol who I understand offers private consultations regarding diagnosis of ADD or ADHD".

So, that was May - the beginning of May. I think a little earlier, is it right, if we look at D1, you had written to Dr Cosgrove on 26 April - it is the back page of D1 - confirming
the appointment you had made for 21 May?
A   Yes, that is right.

Q   And then you travelled down to see Dr Cosgrove on 21 May, and if you look in C8 - and I am sorry to flit backward and forward between documents - at Divider 6, Dr Cosgrove has written a letter to your GP, Dr Taylor, on that same day. Now you have told us that your recollection of this consultation is that you were in and out within half-an-hour, he asked you some short questions about the date of birth, how D was sleeping and eating and got you to complete a questionnaire and then gave you a diagnosis of Attention Deficit Hyperactive Disorder?
A   Yes.

Q   He asked you a lot of detailed questions, did he not, and you gave a very full history of your son's condition?
A   It was not detailed questions. It was questions in general about D's behaviour.

Q   Well, let us look at some of the detail he sets out in the letter to your GP and see whether or not you agree with the detail and seek to identify where that detail would have come from. It starts off, "Mrs D heard about ADHD from a parent of an ADHD child and made contact with me via the ... support group. I was able to see D with his mother this afternoon". Now, did you tell him about how you had come to make contact through the support group?
A   Dr Cosgrove?

Q   Yes?
A   I probably did, yes.

Q   "Mrs D told me that D has poor concentration, a short attention span, is very distractible and frequently bored". Is that an accurate summary of what you were telling him?
A   These were all tick questionnaires that were written in a box that I ticked off. When you see Dr Cosgrove's questionnaire typed, there was about 20 questions written down and it is "Easily bored?", "Loses concentration?", and you tick them as you go along as to what affects your son - your child.

Q   "He concentrates [very] poorly at school where he hardly puts pen to paper"?
A   That was also given in a school report.

Q   "He is hardly learning anything", school report?
A   Yes. I had taken down school reports and behaviour reports that I had received from the school. I took them down to Dr Cosgrove.

Q   "He is impulsive not only when in a temper. He has jumped out of windows, lit fires and once climbed on to the roof with roller skates on". Where did that information come from?
A   That has probably come from myself.

Q   Right. "He has daily tempers and will smash up furniture in the house such as two coffee tables, two pot plants, ripped mother's briefcase and poured hot tea on the floor -
A

all in one temper”?
A Yes, that is correct.

Q All from you?
A Yes.

B

Q "He is aggressive to his two siblings, and is frequently fighting in the playground at school”. Well, the report of aggression to his two siblings ---
A No, it was not his two siblings.

Q ... that was his brother and sister?
A Yes, but his sister was a baby at the time. He never went near her. She was only months old. But my older -- my other child who is now twelve, yes, he could be pretty rough with him.

C

Q Right. I think at the time he was four, was he not?
A Yes. When my second son was born, yes.

Q "... frequently fighting in the playground at school", would that have come from the school reports?
A Yes. Well these things were all written down on school reports and, because D was so disruptive in class, he was constantly on what they call a behaviour programme where it was written in detailed boxes every day of his behaviour at playground, at lunchtime, in the classroom and how the teachers dealt with it and did he get a happy or a sad face that day. And so it was all very detailed, and that is the reason I took them down to Dr Cosgrove because they were so detailed to let him see exactly what was happening in D's life at school.

E

Q Right. "He has no friends as a result of acting immaturity, and annoying, shouting and swearing at them". Has that come from you?
A Yes, probably.

Q I am sorry?
A Probably, yes.

F

Q "He has low self-esteem and does not like himself thinking that he is stupid". Again, your assessment?
A Well I could possibly have said that, but these are also questions that were in Dr Cosgrove's questionnaire.

G

Q "He has no motivation to do what needs to be done or what he is asked to do", your source again?
A Again, that could be the questions written down in the box.

Q "He is always on the go, never sitting still and runs when he could walk"?
A That could probably be mine.

H

Q "He is clumsy and constantly trips and falls", you?
A It could be me, or it could be the questions that were in the box. There were so
many questions and they were all similar to what you are explaining.

Q "His mother said that for the six hour trip to Bristol his bottom was on the seat for just 15 minutes"?
A That is right, because Dr Cosgrove made a comment to another member who was passing by in the corridor and he said, "This little chap's been travelling down from Glasgow for six hours and hasn't sat down once", and they both laughed.

Q And did you tell him about what the nursery school staff thought, and indeed you thought, that you considered him to be hyperactive as a preschooler?
A Yes.

Q And I think it was in that context that did you report the comment by the nursery school member of staff that he had "ants his pants"?
A That is correct.

Q "And she still ...", that is a reference to you, "... considers he is hyperactive", and he says that he would certainly agree with that observation of him today. Again, did you tell him that you considered him to be hyperactive?
A I would be lying if I said "Yes" or "No".

Q You cannot remember?
A I can't really remember, no.

Q "He has been suspended twice so far in his school career", is that an accurate report from Dr Cosgrove?
A Yes.

Q And that would have come from you, would it not?
A Yes.

Q Then Dr Cosgrove gives his considered diagnosis and then he describes him being like his biological father. He then goes on to give a description of father:

"Poor concentration and poor motivation at school and left unable to read, write or spell. He is currently an alcoholic".

Did that information come from you?
A Yes.

Q Then he sets out the recommendation of Ritalin and what he is recommending by way of dosage. I think you said that it was to start off with at half a tablet a day, is that your recollection?
A Yes, from what I can remember.

Q I think what he says here is to start off 5 milligrams, I think that should be a.m., not o.m., and 5 milligrams at 4 p.m. 5 milligrams is half a tablet, so that is a total of one tablet a day for two days, followed by 5 a.m., 5 lunchtime, 5 4 p.m., 5 7 p.m. so that is doubling the dose to two tablets a day for four days. Do you recall that?
A Yes.

Q Followed by 10 a.m., 5 lunchtime, 10 4 p.m., 5 7 p.m. which would take it up to 30 milligrams (in other words, three tablets a day) until the first telephone appointment. Do you accept that those were the recommendations he gave?
A Yes.

B Q He goes on to say:

“I will have a series of telephone appointments with his parents in order to monitor his progress and to find the optimum dosage and frequency through the day. I have told his mother that I am raising the dosage faster than I normally do because of the seriousness of the current situation. Hopefully, the 7 p.m. dose will improve his sleep pattern since he does not get to bed nor to sleep until after midnight.”

C I think you mentioned that he asked you about his sleeping patterns.
A Yes.

Q Was that right, that at the time he was not going to bed nor getting to sleep until after midnight?
A Yes, it has always been the case with D since he was a small child.

Q Then he goes on to talk about Ritalin in the next paragraph four lines down:

“It does tend to cause a fall in appetite and D’s is poor because of his hyperactivity and poor concentration so treatment may well improve his food intake”.

D Did you tell him about your son’s poor appetite?
A It was all in the case scenario when D was born that he did not eat and did not sleep so that was well documented from when he was a baby.

Q But beyond the school reports did you take any other records down with you to Dr Cosgrove?
A Not that I can recall, no. I think I may have taken down one, but I am not too sure, from Dr Robinson who was the first doctor that I saw before I saw Joanne Barton, because I remember Dr Cosgrove saying that Conduct Disorder was ADHD.

Q He comments on the inpatient assessment of Yorkhill, I think, in the third paragraph on that page.

G “He was admitted to Yorkhill for four weeks in March 1996 under the care of Dr Joanne Barton. His mother told me that a diagnosis of Conduct Disorder was made and that she was informed that D needs cognitive therapy. He was also seen by Dr Jean Robinson for three appointments and, once again, Conduct Disorder was diagnosed and cognitive therapy recommended. This cognitive therapy has not yet started. His mother told the child psychiatrists that her son would not be able to concentrate well enough to benefit from counselling, and I am in full
agreement with her on this”.

Again, is that an accurate record of what you were telling him at the time?
A Yes, it would have been.

Q Then there is a discussion about Ritalin and the final paragraph on that page:

“I have made out a private prescription for Ritalin but I know that his parents would very much appreciate it if you would copy it down on to an NSH scrip. On each occasion that I alter the dosage, I will send them a fresh private prescription to bring to you. You may care to keep them in his file”.

Just on that subject of prescriptions, can you look back, please, to page 1 of that tab 6. We have here a document setting out a dose of Ritalin on a piece of headed notepaper from the Bristol Priority Clinic, clearly, a subsequent letter/prescription from 21 May dated 5 June and you will see written “Specimen. This is not a prescription” underlying it all. Do you recall receiving his recommended doses on paper like that?
A I cannot remember.

Q We will come back to that. That is later on in the history so I do not want to get out of tune. Mrs D, all this information that you gave, whether by way of written questionnaire or in questioning by Dr Cosgrove, would have taken considerably longer than half an hour, would it not?
A No, it did not.

Q But in any event did you think he was listening to you and taking in what you were saying?
A Yes, of course.

Q Then on 27 May (it is not on the chronology but if we look to the bundle D1) I think you write again to Dr Cosgrove, this is the second letter, advising Dr Cosgrove that D had started his medication on Friday 24 May:

“So far so good. The only side effect I can see at the moment is his appetite which you told us about. The other thing I need to mention is that my own doctor will not prescribe Ritalin for D. What they have said to me is that I have gone outwith the NHS and gone against Yorkhill Hospital, Glasgow and I will have to get my prescriptions from you privately. I would be most grateful if you could advise me what to do as I do not want D to run out”.

So you were not getting much help from, I think, was it Dr Taylor, your GP at that time?
A Yes, that is right.

Q Would it be fair to say that she effectively washed her hands of you and the treatment of your son?
A In the treatment of Ritalin, yes.

Q If we look, please, at the GP records, D30, at page 213, again, Mrs D, I appreciate these are records you may not have seen before, I do not know, can you help? These are
handwritten records by your son’s GP. Have you seen these before?
A  No, I have not.

Q  There is an entry there for 4 June 1996 which if I have got the writing correctly says:

    “Spoke to Dr Barton re Ritalin. She transferred me to Dr Robinson. She agreed that Ritalin could be prescribed and so I will agree to do that” or “do this”.

You presumably on 4 June would not have attended with D to speak to Dr Taylor or would you? Can you help us with that?
A  I cannot remember.

Q  What I suggest is that on 3 June you made your first phone call to Dr Cosgrove and told him that your son had been on Ritalin for 11 days, was very well, but was better on 10 milligram tablets and when confined to the five milligram tablet his aggression would increase.
A  I have never telephoned Dr Cosgrove to speak to him over the phone. I have only ever spoken to a female to make an appointment, met with him when I went down to the initial consultation, two telephone calls. Everything else has been done by letter. I would not know how to telephone the doctor and suggest that he give D a higher dose of Ritalin.

Q  Have you never spoken to Dr Cosgrove since ----
A  Twice on the phone when he called me in his consultation.

Q  He called you?
A  Yes.

Q  Did he call you on 3 June?
A  He may have done. Does that tie in with two weeks after when I initially saw him? If it does then it will be. I said he called me two weeks after the initial consultation.

Q  Your initial consultation, we know, was on 21 May, approximately two weeks. (The witness nodded). Just help me with the conversation. You have written saying that your son started Ritalin on 24 May, so by 3 June, if my arithmetic is right, he would have been on Ritalin for 11 days or thereabouts.
A  Yes.

Q  You were, I suggest, commenting then he was very well, but better on 10 milligrams three times a day.
A  Where does it say that?

Q  You will not see it in the letter. I am just suggesting that that is the gist of your telephone conversation.
A  No. I do not know anything about medication. It was up to Dr Cosgrove to advise me. I was telling him how I felt D was on the dose that he had given him. It was then up to Dr Cosgrove to decide if he increased the dose. It was not up to me. I did not know enough about the drug or anything about the drug.
Q All I am suggesting is that you were telling him that on the larger dose he was better than on the smaller half tablet dose where his aggression was not reducing.
A That is possibly true, yes.

Q And that his appetite had fallen. Do you recall telling him that?
A Over the phone, yes.

Q Did he ask you about your son’s weight?
A No, not that I can recall, but obviously if you are not eating you are going to lose weight.

Q I suggest he asked you about your son’s weight and that at that stage it did not concern you.
A I do not believe that to be true, because I was concerned that D was not eating properly because of the drug and I said this over the telephone to Dr Cosgrove. That was why Resperidone was introduced, not because Ritalin was not working. Ritalin was doing what Dr Cosgrove said it would do. It would calm D down and help him concentrate in class. He did tell me that D’s appetite could go and it may stop him from sleeping and that is exactly what it did do and when Dr Cosgrove phoned me I explained this to him. That is when he suggested he introduce a second line drug.

Q We will come to that. I suggest that was not suggested at this telephone consultation. You told him that as far as sleeping was concerned, he was still awake up until 1 or 2 a.m.
A That has always been the case with my son. He has never slept since he was a baby.

Q You confirm what you said in your letter of 27 May that your GP was at that stage (and I am suggesting this is 3 June) refusing to prescribe, but as far as you getting on with your son was concerned, at that stage it was fantastic.
A Yes. There was a marked difference in his behaviour, as Dr Cosgrove said the drug would do.

Q Dr Cosgrove agreed to call you again when the situation as to whether or not you were going to get a prescription from your GP was sorted out. Do you recall that?
A I had two telephone calls with Dr Cosgrove. When I had gone to see my GP after initially seeing Dr Cosgrove they were not going to prescribe Ritalin and then changed their mind and decided to prescribe Ritalin. The second telephone call I believe ----

Q Can I just stop you there, Mrs D, and just help you on that?
A Yes.

Q The change of mind, I think, occurred, did it not, on 4 June, if we look at Dr Taylor’s notes at 213, where she says she spoke to Dr Barton about Ritalin and then she was put on to Dr Robinson who agreed that Ritalin could be prescribed, “so I will agree to do that”’? So as from 4 June is it right that Dr Taylor was agreeing to prescribe Ritalin for your son?
A Yes.
Q Indeed, we see another entry on that page also dated 4 June where the Ritalin dose that Dr Taylor was agreeing to prescribe is set out there - 10 milligrams twice a day plus 5 milligrams twice a day, so that is two full tablets and two half tablets, taking it to 30 milligrams a day.
A Yes.

Q And the times are set out there. She has noted above that:

“Ht and wt 3 monthly” then an arrow to “P/N”

which I suggest probably means practice nurse. Were you there on 4 June to pick up the prescription, can you recall that?
A Of course, yes.

Q Do you recall being told that your son’s height and weight would be checked on a three month basis.
A Yes.

Q Can I suggest that on 5 June two things happened. First of all if we look at page 212 in that bundle, we see, I think it is an entry for 5 June, we see Dr Taylor again when she notes, “Has been on Ritalin, ‘I feel good’, no problems. Then underneath, I think that may be the words, “Mum, slightly reduced appetite” and your son’s height and weight were noted. Does that ring any bells at all?
A Yes, if it is written down there I was there with the doctor.

Q On the same day I suggest Dr Cosgrove telephoned you again and you reported to him that Dr Taylor had agreed to prescribe and you told him the dose that was being given, namely 10mg, 5mg, 10mg, 5mg during the day and that things were going well. Can you recall that?
A I recall speaking to Dr Cosgrove, yes, but I do not recall on what actual date it was.

Q I can understand that?
A It was not Dr Taylor who set out the prescription, it was Dr Cosgrove. She was acting on his.

Q He had given a recommendation in a letter to Dr Taylor?
A Yes.

Q Did you, during the conversation, tell him what the response from the school was, namely that the teacher cannot believe the change?
A I do not recall saying that.

Q Just to help you on that, Mrs D, can I take you to the second letter that we have in the bundle from Dr Cosgrove in C8 at divider 6? It is dated 17 July, 1996. It is page 5 of that divider, pages 5, 6 and 7. It is dated 17 July. Writing to your GP:
“Since I wrote to you last, I have had three telephone appointments with Mrs D regarding D. I have taken the Ritalin dosage up from 5mg twice a day to 10mg om; 5mg lunchtime, 10mg 4pm; 10mg 7pm”

- so that is 30 mg a day -

“Initially D’s aggression ceased on a 10mg dose and his mother was very pleased with 30mg per day. On this dose, his teacher could not believe the change in him.”

Do you recall telling Dr Cosgrove that?
A  I do not recall but I am not saying that that is not true. It could possibly have been said over the telephone. I do not know.

Q  That, I suggest, was said at that second telephone consultation on 5 June. Just carrying on, what I suggest you were telling him at that stage, at home he got angry when the tablets wore off and that the 5mg tablet was not as good as the 10mg tablet. Would that sound right?
A  Well obviously yes, because if the half a tablet was not as strong as the 10mg tablet then I would probably say that was correct, I did say that.

Q  Were you telling him at that stage that your son’s appetite had gone down, certainly at breakfast and lunch and that he would only really eat at supper time?
A  Yes. He would only eat later on at night, once the tablets had worn off, which could be about nine o’clock at night.

Q  Were you asked about his weight and did you tell Dr Cosgrove that it was five-and-a-half stone?
A  I must have done.

Q  And commented, “He always looked thin, never been a great eater”?
A  He has not been a great eater. That is something I have always said.

Q  You were asked, I suggest, about his sleeping patterns and you mentioned that he would get to sleep about 11.30 pm, that the half a tablet of Ritalin at 7pm would last for about one-and-three-quarter hours?
A  Yes.

Q  That is right?
A  Yes.

Q  You expressed an intention of going to see Dr Barton to tell her what had happened to your son on this course of treatment?
A  Yes.

Q  Did you, in fact, go and see her or did you subsequently write?
A  No, I wrote a letter to her.
What I suggest happened also on that date was that Dr Cosgrove suggested increasing the Ritalin dosage up to 35mg. That is to say, converting the half tablet at 7pm to a full tablet at 7pm.

Yes.

Do you recall that?

Yes.

That, I suggest, was 5 June. Then if I can take you to a letter your GP wrote, Dr Robinson, on 21 June. We will find that in the other bundle, D30 at page 168:

“This young boy came out of Yorkhill in March of this year and I understand you will be offering the family further input. You will have seen the letter describing his visit to the clinic in Bristol and he is now on Methylphenidate Hydrochloride 35mg a day. His mother and D himself both report a marked improvement. However, it is agreed that it would be welcome to have input in your department as well.”

Then on 11 July, if you could go in that same bundle to 212, it is not very easy to read, Mrs D, but what I am suggesting there is a note of a prescription being given to you for your son for 112 tablets of Ritalin and the dosage being set out there as 1 qd - four times a day, which would suggest a total not of 35mg a day but one of 40mg a day. The comment underneath that, “Long talk with Mum about prescribing.” Is that Dr Taylor’s consultation or was it another doctor?

Excuse me, which part are you reading?

I am sorry? Page 212. If you look down from the top there is an entry which says 11/7/96. Do you see that?

Yes.

It appears to say, prescribing treatment - it looks like an ‘R’ with a cross at the bottom, “Methylphenidate, 10mg x 112” and then “1 qd”. What I am suggesting is you were being told by your GP that the dose was to be one tablet four times a day

Yes, possibly, yes.

Were you only seeing Dr Taylor at that particular surgery, or were there other practitioners at that surgery

Dr Taylor was a partner of the surgery. It was Dr McCall.

I do not know whose writing that is, but one of the doctors?

It was mainly Dr McCall that I saw. Dr Taylor was a female doctor.

Mainly Dr McCall that you saw?

Yes. He was not too happy about putting D on Ritalin.
Q He seemed to be increasing the dose, therefore, from 35mg a day to 40mg a day?
A I do not know if that was Dr McCall or that was Dr Spence, because I had moved home and it may have been Dr Spence. I am not sure.

Q I think if we follow the chronology we may find that you did not change doctors until the end of July, but let us see where we go on that. You then have, I suggest, a third and what transpired to be a final telephone conversation with Dr Cosgrove on the 17 July, after which he writes the letter that we see at divider 6, page 5. Perhaps if you could go back to that letter, please. What I am suggesting is that between the month that had transpired between 5 June and 17 July, things had deteriorated somewhat inasmuch as his aggression had returned and that his temper had increased and he was being violent again. If we look at the letter in the first paragraph about six lines down where Dr Cosgrove says:

“His aggression has returned and he is hitting his mother now on a daily basis. Yesterday he would not take his morning dose of Ritalin and then came down to set fire to the living room carpet. He smashed the telephone at the same time, together with kicking and spitting.”

Do you recall telling Dr Cosgrove about that on the telephone?
A I must have told Dr Cosgrove otherwise he would not have known. I do not believe it was on the telephone. I can only remember speaking to him twice.

Q Dr Cosgrove commenting:

“Clearly he needs the Ritalin but I cannot increase the dose at present because his appetite has fallen considerably and he is awake until after midnight. I have therefore decided to add low dose Risperidone to the Ritalin and have asked his mother to give him”

and then sets out a schedule, 0.5mg twice a day for two days, then 0.5mg three times a day for the next three days and then 0.5mg four times a day thereafter until a further telephone appointment in about ten days after starting the Risperidone. As you say, he said to you that the Risperidone would deal with the aggression and help his thinking and help him sleep and increase the appetite?
A Yes.

Q Did he invite you to write to him telling him when the Risperidone was started?
A Not that I recall, no.

Q Going back to your son’s GP records, again to page 212, if you would, please. We have got an entry there, I think probably Dr Taylor’s entry, mentioning that she had received a letter addressed to her, she had received a letter from Dr Cosgrove recommending additional Risperidone. Dr Taylor discussing that with a prescribing advisor, advised against prescribing. I cannot read the next word, something like,
"You were advised of that" - something - "above to Mrs D. In addition the product is unlicensed for this use and none of us has any expertise" - something - "for this. Therefore, would be unwise to prescribe. Accepting of reasons. Mrs D will speak to Dr Cosgrove."

Do you recall speaking with Dr Cosgrove the following day, 25 July and telling Dr Cosgrove that your GP was refusing to prescribe Risperidone?
A No, because I had written Dr Cosgrove a letter. I was in the process of - I had got a private prescription sent through the post by Dr Cosgrove for Risperidone and there was, I cannot recall how many tablets, there may have been about 20 or 30 tablets on a private prescription. I had gone to Boots the Chemist and bought about ten tablets and had gone to see my GP. The GP had advised me no, they were not prepared to prescribe the other drug and also advised me because I had gone privately, this was me suffering the consequences of going privately because they did not have enough knowledge of the drugs and were not prepared to prescribe them for me. Between that space of time, about three weeks, I was moving home and I had moved back over to where I originally came from and I wrote to Dr Cosgrove to say that they were not prepared to prescribe Risperidone.

Q Right.
A Then I registered with my new GP and I spoke to him about it he was prepared to prescribe both drugs for D.

Q Right. Do you recall when you wrote to Dr Cosgrove? I am looking at D1, and the only letters that we have got is your initial one of April which we have looked at, 27 May which was in relation to Ritalin at that stage and the only other one we have is 23 September which is considerably later than this. Do you think you wrote this at around ---

1. A I think it is the 20 September one, because from when Dr Cosgrove gave me the private prescription for Risperidone I am going to my old GP who would not prescribe it, I had enough Risperidone at that point to do me and, when I moved home, my new doctor prescribed it and that is in the letter as far as I remember.

Q Right. You see, you do not say in your letter of 23 September that your GP had refused to prescribe Risperidone. You are just confirming that Dr Spence has no objection to prescribing both the drugs - Risperidone and Ritalin. So, you do not recall talking to Dr Cosgrove and telling him about the refusal to prescribe Risperidone by Dr Taylor?
A No, I cannot remember the first conversation that I had with Dr Cosgrove regarding Ritalin. What he had said to me at that point was that, if the doctor would not prescribe me the Methylphenidate, he would then be able to prescribe me a cheaper drug called - and correct me if I am wrong - dexamphetamine, it may have been, which is a cheaper form of Ritalin.

Q Right.
A Risperidone was not brought up at that point. He more or less said that, if the
doctors were not prepared to prescribe for me, he would give me a cheaper drug to buy to save me money, from what I can remember.

Q Well, let us move on. I suggest that at about 30 July was when you changed over GPs. If we look at the GP records, just before we get to 30 July if we look at 26 July Dr Taylor, four lines or five lines down, has asked for an urgent referral of D to Dr Robinson. There is a note then on 30 July:

"Spoke to Dr Robinson. She will see them in two weeks",

although she goes on to say:

"She doesn't feel her input very appropriate and no ..."
(something) "... referral to counsellors or social work".

And just if we go over the page to 211 this is when I suggest you transferred to Dr Spence, and somebody has written at the top:

"Dr Cosgrove, Bristol, diagnosed ADHD. On Ritalin 10 mg QD ...
" (four times a day) "... Risperidone half a tablet BD" (which I think is twice a day). Noted for registration",

and then on 2 August I suggest Dr Spence issues a prescription for Risperidone, 30 tablets, with the direction to take half a tablet twice a day?

A Yes, that is right.

Q Right. And we note also further down on 22 August your son's height and weight being recorded. And then on 23 September is when you write to Dr Cosgrove, the letter that we have seen at D1, where you tell him that you had recently moved house and changed doctor:

"D is doing very well with both drugs. Ritalin Risperdal",

as you call it there. You tell him about your new doctor:

"... is very helpful and has no objections to prescribing the drugs. I am not on the telephone yet but hope to be in the near future. I wish again to thank you so very much for your help. If it had not been for you I think D would probably be in care. I do not want to break contact with you and I will send your money as soon as possible".

Now, in fact I think that was the last time you wrote to the doctor?

A Uh-huh.

Q And, indeed, I think the last time you spoke to him was back at the end of July?

A Uh-huh.

Q Now at that stage he would have had your new address, but would not have had
your telephone number?
A  No, he did not. I never contacted Dr Cosgrove. That was the letter. That was the first letter that I had written to Dr Cosgrove since I spoke to him.

Q  Right.
A  As you can see, I have written in the fees and not having contact with him because I did not pay for the two telephone consultations with him. I moved home without contacting Dr Cosgrove. I received round about August or September a survey from Dr Cosgrove and Dr Bramble from Nottingham University, to see how my son was doing on Risperidone and to say that Dr Cosgrove had over 200 patients that he had been treating, and that prompted me to write a letter to Dr Cosgrove. And it was strange because I do not know how they got my new address because I never informed him that I was moving and I did not inform him of my new address. Everything happened so quickly. I was in and out my new house within a month.

Q  So, your letter of 23 September with the address there ---
A  Uh-huh.

Q  --- how long did you stay there for?
A  I was there for two years.

Q  Right. And you said, "I am not on the telephone yet but hope to be in the near future"?
A  That is right.

Q  Right. And so Dr Cosgrove would have had your new address, but not any telephone number?
A  Once I had written this letter after 23 September, yes.

Q  Right. And thereafter you did not have any input from Dr Cosgrove on appropriate treatment of your son?
A  No.

Q  It came from Dr Spence?
A  That is right.

Q  And specialists he referred you or your son to?
A  Yes.

Q  And, as far as you know, did either or any doctor treating your son make any contact with Dr Cosgrove ---
A  I am not aware.

Q  --- about future treatment?
A  I do not know.

Q  And if I can take this quite quickly, if we look at the chronology, Mrs D, D31, I think on the same day that you wrote to Dr Cosgrove you wrote also to Dr Barton and Dr Robinson. The letter you wrote to Dr Robinson I think we find that in C8, Divider 6, at
Page 10, where you tell her about -- I do not know if you have got that? You tell her about your trip to Bristol, being put on Ritalin:

"D is such a different person now and so much happier within himself. As I am a patient of Dr Cosgrove I feel I should continue to keep D with him, rather than see you, because you do not believe he has this condition. If you wish to write to me I have moved house and my new address is at the top of the page".

Well, in fact - in fact - you did not keep your son with Dr Cosgrove because thereafter he was with Dr Spence?

A That is right, because I could not afford Dr Cosgrove's fees.

Q Right. And I think you also wrote to Dr Barton and it is C2, but I am not sure whether the Committee have C2? I am afraid I have not had it copied.

THE CHAIRMAN: There is only one copy available from the Secretary. Do we need to run off some copies?

MR MORRIS: Sir, I do not think it matters at this stage:

Q (To the Witness) Do you recall writing to Dr Barton as well as Dr Robinson?

A 2.

Q Yes.

Q And, if I just read from it, I hope you will take it from me as correct. Again you tell her about Dr Cosgrove and the diagnosis he made and then you comment:

"D is a changed boy now while not perfect, but then what children are? My old GP prescribed Ritalin, as does my new one. Such a pity D had to go through so much and your team were unable to help him. For the sake of all the other children who come to see you, it would be really helpful if you would listen to what mother says and try to help".

F Did you take the view that Dr Barton had not really listened to you?

A Yes.

Q Then going to back to the chronology, Mrs D, if we may, at D31, this is really extracts from your son's GP records. In 1997 your GP, Dr Spence, was talking about there being problems over lunchtime, he notes his height and weight and took the decision to increase the Ritalin to 50 mgs a day for 28 days and the Risperidone to increase that to 2 mgs a day. That is to double the dose, do you remember that?

A Yes.

Q And then it came back down again I suggest in March of that year and back up again to 50 in April of the same year, and then on 19 May - and we can follow this in the actual record at 211 - your doctor, or your son's doctor, is reporting that Risperidone is not helping, that your son is aggressive and therefore took the decision to try stopping it
and to prescribe clonidine in its place. Do you remember that?
A    Uh-huh.

Q    That did not appear to work and on 28, shortly after, at Page 210, the note was that your son had been in trouble again, aggressive at school and the scouts. Query what to do, and decides to increase the Risperidone to one tablet four times a day and so to double it again. Do you remember that?
A    Yes.

Q    And that appeared to work to some extent because on 5 June he records, "Better therefore continue", and height and weight are recorded, and then in January 1998 the Ritalin he records as not helping and he substitutes or suggests dexamphetamine instead. Do you remember that?
A    Yes.

Q    On 20 January he refers your son to Dr Steer, a Consultant Paediatrician, or expresses his intention of referring him to Dr Steer, and comments that the dexamphetamine was no use and therefore back to Ritalin, and the dose being given I suggest was 60 mgs a day?
A    Could I ask you why it is written down here 75?

Q    Where is it written 75? You may well be right.
A    "Advises increasing Ritalin to 75 mg" on 30 January.

THE CHAIRMAN:   It is in the chronology at D31, the final entry.

THE WITNESS:   D was never on 75 mgs.

MR MORRIS:   (To the Witness) Yes. Well, what I suggest is on the -- we may have got this wrong. Well, I think it will become clear. If we look at the 23 January letter to Dr Steer at 141, where Dr Spence sets out how he has dealt with your son, the first paragraph:

"After he saw Dr Cosgrove, he was started on Ritalin with a great deal of success. His most recent problem is that he is now reaching maximum doses of Ritalin and still finding that at certain times of the day his behaviour is quite difficult. His mother has recently been asked to take him away from the scouts as they can't control his behaviour. His present regime is of Ritalin, up to 60 mg per day, with Risperidone 1 mg four times a day. Just after new year, his mother and I ask discussed this and thought we would try him on Dexamphetamine 5 mg twice a day, but his behaviour became extremely aggressive and she couldn't cope with this after 2 or 3 days without Ritalin and therefore the dose of Ritalin was re-started to reach the maximum of 60 mg per day".

I think that is where I got the 60 mgs a day from.
A    Yes, but it has got 75 marked down somewhere.
Q Well, we will come to that:

"I wonder if some of the problems they are having, is that he is now reached a considerable size and despite Ritalin having a detrimental effect on growth, he seems to have put on 4 kg and 2 inches in about the last 4 months ... I thus wonder if you have any suggestions as how to go about dealing with his medication problems, and do you feel that the change in height and weight are anything to be worried about".

And then we get Dr Steer's response, at Page 140 and 140A, to Dr Spence:

"I think your first response in attempting a switch to Dexamphetamine was really quite appropriate, but you don't seem to have got as far as being able to put him on an equal dose ... I don't think there is any evidence (and this was reviewed fairly thoroughly recently) indicates that final stature is significantly affected by long-term neurostimulant usage and I think there is every expectation that these drugs will continue to be useful even into adulthood in ADHD ... I would be more than happy to see D if you wish. Again I wouldn't be too worried about growth and would be happily reassuring to parents. Regular checks of blood pressure are prudent, say 2-3 monthly to make sure hypertension doesn't develop but I haven't seen any child with this so far".

And then he goes on to say:

"In D's case if he is in the severe category of ADHD, i.e. with complicating Conduct Disorder and potential Oppositional Defiant Disorder then one could be excused I think for increasing the Ritalin even further and it is usually tolerated even in doses that you would think would start to cause side effects. In the first instance then I would suggest increasing the Ritalin to two-and-a-half tablets ... TDS ...",

and TDS is three times a day. Now, that is a total of 75 mgs? Right, well D never received that.

"... making sure that it is given as nearly at 4 hourly intervals as is feasible.

I don't have a huge amount of personal experience with Risperidone but those cases I have seen that have been assessed in the past by Dr Cosgrove do seem to have done well on this drug particularly from the point of view of ameliorating appetite suppressing effects of Methylphenidate, and also helping to
minimise sleep problems ..."

Was D’s Ritalin increased to 75?
A No, it stayed at 60.

Q But all that was done, of course, without reference to Dr Cosgrove.
A Yes.

Re-examined by MR PEARCE

Q Just one or two matters. You have been taken, Mrs D, through that period from late 1996 and through 1997 when it is apparent that Dr Steer in particular was a consultant who was referred to by Dr Spence the GP.
A I have never spoken to Dr Steer. Dr Spence must have taken it upon himself to go to him.

Q So it was Dr Spence who was, as far as you were aware, in charge of the dosage and taking responsibility for that.
A Yes. Well, Dr Spence did not have much idea about the dosage of Ritalin or Risperidone.

Q I understand. Mr Morris has referred you to a number of the records. I do not think we need to go back through them, but he has referred to a number of records when either dosages have changed or actually the drug that was being prescribed was changed by Dr Spence. You recall there were a number of such occasions.
A Yes.

Q On the occasions when the medication was changed did Dr Spence see your son?
A Yes.

Q Always?
A Not all the time, no. There were times when I did go over and see him myself to speak about D’s behaviour and he would suggest, “Why don’t we try it this way?”

Q We see I think from the records a reference to height and weight being measured.
A Yes.

Q One other matter. If you can just look back again to the bundle that is called C8, the one with the tabs in it, and tab 6, of course, the letter at page 10, it is a letter to Dr Robinson. I hope I summarise the tone of it correctly. You were saying to Dr Robinson that things were much more satisfactory now Dr Cosgrove had become involved in assisting, is that right?
A Yes, that is right.

Q If you would just turn over the page to page 11 of that tab, this is a letter written by Dr Robinson on 25 September 1996. Do you recall receiving this letter?
A Yes, I do.

Q “Dear Mrs D,
Thank you for keeping me updated about D and his progress. I concur with your view that the diagnosis made by Dr Cosgrove is appropriately treated by him.”

A Yes.

Q So that was the response you received from Dr Robinson.
A Yes.

Questioned by THE COMMITTEE

Q Just for clarification, the time when you visited Dr Cosgrove at the Bristol clinic, when did you actually receive the questionnaire? Was it posted to you or given to you while you were in the consultation?
A For the Risperidone?

Q No, the questionnaire that you completed.
A The questionnaire was given to me when we went to see him at the consultation.

Q And you completed this and then, what, took it into ----
A No, I completed it as I sat beside Dr Cosgrove.

Q Again, just to confirm, did Dr Cosgrove undertaken any type of physical examination on your son?
A No, he did not.

Q And no weight was taken at the time?
A No weight, no height. He did not even acknowledge D was there. The questions were mainly addressed to myself.

Q Was your son’s blood pressure checked?
A No.

Q Not even maybe by a practice nurse?
A Not when I saw Dr Cosgrove, no.

THE CHAIRMAN: Could I seek clarification, Mrs D, about the letter of 23 September in D1? It has been suggested that there were three telephone calls but you indicate that there were two telephone calls. In that letter you indicate that there is a fee of £54.
A Yes.

Q I am just checking my arithmetic.
A I know. I was looking at that figure myself. The telephone calls may have been £27. I was thinking of the £25 consultation fee.

Q So you think it might be £27 and that would explain two telephone calls in your mind.
A Yes, that is right.

Q In the final telephone call/conversation with Dr Cosgrove was it indicated to him
that you were not going to continue to receive calls from him because you could not afford them?
A No, I was too embarrassed to say anything to Dr Cosgrove.

Q Were the bills for the telephone calls raised after the telephone call or was it anticipated that you would pay in advance of the telephone call?
A It would be anticipated that Dr Cosgrove would phone me and then he would bill me for the consultation over the phone and I would pay them by cheque.

Q So what you are saying is that you did not indicate in this letter that you did not want any more telephone consultations.
A No, I did not, no.

Q And you did not indicate on the telephone.
A No, I did not. I thought I could afford the telephone calls and was going to pay Dr Cosgrove but my circumstances changed.

Q So no further telephone calls came from Dr Cosgrove.
A No.

THE CHAIRMAN: I think these are all the questions from the panel. Mr Pearce, do you want to come back on any of these points? I can see Mr Morris getting set to come back.

Further questioned by MR MORRIS

Q Mrs D, just in relation to the charges, I have suggested there were three telephone calls. Two took place within two days of each other, 3 June and 5 June. What I would suggest is that there was only one charge in relation to those two calls.
A No. There was only ever two calls that I spoke and that was in relation to how D was with the Ritalin and then the second line drug that was being introduced which was risperidone.

Q Then in relation to the anticipation that he would call you to consult with you, you were too embarrassed to tell him that you were not going to be able to afford any future consultations.
A That is right.

Q He did not have and never did have your new telephone number at your new address, did he?
A No, that is right.

THE CHAIRMAN: Mr Pearce? That concludes the evidence. All that remains for me, Mrs D, is to thank you very much for coming to assist us and you may now stand down.
A Thank you very much.

(The witness withdrew.)

MR PEARCE: Sir, if I may then explain the situation in respect of the outstanding evidence which I seek to adduce, we are, of course, to hear again from Professor Taylor
in the morning. We had left the position last week, you will recall, that Dr Thomas who
gave evidence in respect of Patient F was not cross-examined and my learned friend had
asked for the medical records relating to Patient F. I had said to the Committee that there
had, it seemed to me, been an oversight in respect of those patient records. I have now
seen the full correspondence file and the position appears quite clear, in my submission,
(I do not think I need to refer you to the letters) that we had indicated in January that we
could not get those records because we could not get consent.

In any event, what has happened since last Thursday is that we have contacted the
appropriate Trust and the appropriate unit. They have confirmed essentially that there
ought to be records relating to Patient F but that they cannot find them. So I am afraid
that we have drawn a blank. They can give us no further information about where the
records might be and, reading between the lines of the communications we have had, they
(that is, the people with whom we have been communicating) have probably lost them,
because they clearly anticipated they ought to have them and then told us they could not
find them.

My learned friend tells me in that situation that the records of Patient F cannot be
produced that he has no questions for Dr Thomas, so I will not need to recall her.

You will recall also, I think, in the course of the same conversation that I mentioned the
question of the records of Patient H to whose evidence Dr Dover referred. Those records
have been obtained and have been made available to my learned friend. So the only
remaining evidence that I seek to call now is that of the remainder of Professor Taylor’s
evidence and any cross-examination of him and he will be available in the morning.

MR MORRIS: Sir, I think it was indicated that I would seek to interpose before the close
of the Council’s case two of my own witnesses. I have alerted my learned friend to that
fact. He does not take objection. I hope to be in a position to call them at 2 o’clock.

THE CHAIRMAN: Thank you very much. In that case, we will now adjourn and
reconvene at 2 p.m.

(The Committee adjourned for lunch.)

THE CHAIRMAN: Mr Morris, are you ready?

MR MORRIS: I was proposing to start but I think Mr Pearce may want to say something.

MR PEARCE: Sir, may I raise another issue about medical records. This relates to
Patient A and the position is as follows. It has been correctly identified that Professor
Taylor, the witness whom I called, has fairly recently seen that patient following a
referral to him. My learned friend has asked to see the records relating to that
consultation.

The position appears to be as follows, from what we have discovered this morning. The
records are physically available. We cannot be necessarily sure that they are readily
found until we have them in our hands but in principle the records are physically
available. I think, as we understand it, the Trust policy would be not to disclose those records unless consent were available.

As in the cases of F and H, to whom I referred last week, we will do our part to try to facilitate the disclosure of the records without consent, because consent will not be forthcoming in the available time, but we will do so really on two indications, essentially, sir.

The first one, I have already asked my learned friend this, which is the indication from him that he really does want to see the records. He indicates that he does, so that part is, as it were, dealt with.

The second, sir, is your position in that if you as a Committee see it as being desirable that those records ought to be received in evidence, or at the very least ought to be available to my learned friend to consider whether they ought to be put in evidence. I therefore seek that indication from you. If you do, indeed, give that indication then we will continue to use our best endeavours this afternoon to have those records available tomorrow morning.

THE CHAIRMAN: The Legal Assessor indicates he wants to say something.

THE LEGAL ASSESSOR: Not really. It is the same rule…

MR PEARCE: Regulation 15, indeed so.

THE LEGAL ASSESSOR: It is exactly the same set of criteria as applied in the last case. I do not have any advice.

THE CHAIRMAN: I will check with the Panel members. I think I am getting the signal that we would wish these records to be made available.

MR PEARCE: I am much obliged. The representatives of those instructing me - I am lucky enough to have two before the Committee at the moment in the hearing - will communicate that and we will continue making those endeavours in the hope that we will have those records available for you tomorrow morning. I am obliged, sir.

MR MORRIS: I will call Mrs C, the other of Patient C.

MRS C Sworn
Examined by MR MORRIS:

Q I am going to call you Mrs C in order to safeguard your son’s anonymity. Before we progress any further, though, could you on a piece of paper write down your full name and your son’s full name, please? (Pause. Same handed to Committee)

THE CHAIRMAN: We will call this D32.

MR MORRIS: I am going to call you Mrs C and I am going to call your son C. I know it will be difficult for you to call your son ‘C’ but if you can try. It is in his own interests.
Mrs C, I want to start by showing you a letter that was written by Dr Cosgrove about your son. There is a bundle there, it should be marked C8 in the top right-hand corner. If you look at divider 4 in that bundle, you will see a letter dated 29 May 1999 addressed to Dr Rackham, with a heading, although it is blanked out, which is your son’s name and it is signed by Dr Cosgrove.

First of all, can you help us with this. Was Dr Rackham at the time yours and your son’s general practitioner?
A Yes.

Q If we look at the first line of the letter to Dr Rackham it says:

“Thank you for asking me to see C, whom I was able to meet with his mother and stepfather on 27 May.”

Are we right, therefore, I thinking that Dr Rackham referred your son to Dr Cosgrove?
A Yes, that is correct.

Q Did you have any input into that referral by Dr Rackham?
A Yes.

Q How did you come to hear about Dr Cosgrove and speak to your GP about him?
A I was experiencing a lot of problems with my son at the time and somebody came with a magazine article about children with ADHD. I had never heard of it before. I rang the helpline and on speaking to several people over…

Q You say a helpline - was that the ADHD helpline?
A Yes. Over the course of a weekend, I was given several doctors’ names in which to get a second opinion, I suppose with my son and I chose to take my son and asked my GP if he would refer him to Dr Cosgrove who, through the helpline I had very good feedback so I decided that I asked my GP if he would refer him and that is what he done.

Q I come back to the substance of the letter and the subsequent letter you also wrote, not on that occasion to Dr Rackham but to Dr Moses, which was then copied to you and Dr Rackham. Can you just help us. As a result of that consultation with Dr Cosgrove, did he prescribe for your son Ritalin and Risperidone?
A Yes, he did.

Q Following that prescription, was that a prescription he himself issued to you, Dr Cosgrove?
A Yes.

Q Were there subsequent prescriptions for those drugs?
A Yes.

Q Who issued those?
A My GP. My GP carried the prescriptions and still does.

Q Did anyone conduct any monitoring of your son’s condition following his...
A commencement on Ritalin and Risperidone?
A Yes. I had obviously Dr Cosgrove and my son’s GP would do his height, blood pressure, his weight.

Q How often would your GP monitor height, blood pressure, weight?
A Between eight and twelve weeks. Normally about twelve weeks, depending on how the prescriptions run.

B Q You mentioned Dr Cosgrove being part of the monitoring. What was his part of the monitoring process?
A I had a lot of telephone appointments with Dr Cosgrove. However, saying that, there were occasions when maybe things were not quite right with C. I never had any problems with Dr Cosgrove. If I rang today and it is a bit late in the day, I could guarantee a phone call back tomorrow. On several occasions it was his recommendation that I would take C over to Bristol to see him, which happened a few times.

Q So apart from telephone monitoring, you took your son C to see him again in Bristol?
A Yes.

D Q I want you now to look, please, a little more closely at the contents of first of all the letter Dr Cosgrove wrote to Dr Rackham, which we have got in divider 4 and then, secondly, a letter he wrote to Dr Moses. Just dealing with the first letter, please, I want you to help us as to its accuracy as a report of what you were telling Dr Cosgrove about your son. It starts off by saying:

“His mother told me about his poor concentration, short attention span and his distractibility. He flits from one focus of attention to the next. He is very forgetful of instructions and messages, for example. A summary report of his school years…”

but just pausing there, is that an accurate account of what you were telling him about your son?
A Yes.

F Q Did you take school reports with you to the consultation
A Yes, I did, both from the previous school C had attended and the school that he was attending at that time.

G Q If I could take you to the bottom of the page, the last paragraph on that page:

“I am also concerned about C’s aggression and the quality of his thinking. His mother says that he does not always make sense to her and he is quite illogical at times. She describes him as a compulsive liar, usually in order to get out of trouble. However, his lies can become widened and convoluted and detailed. He has made accusations that teachers at the Pollards Unit hit him and dragged him by
the arm. His stepfather says that C thinks that people are constantly against him and I suspect that C is mildly paranoid.”

Again, are those details given both by you and by the stepfather?
A Yes.

Q Then he sets out the Ritalin and Risperidone doses that he is going to start your son on. He then goes on to say this:

“Mrs C told me that C was seen by Dr Moses, consultant child psychiatrist, when he was five years old but she was given no diagnosis. At this time she was being called into school”

- I think that is a reference to you?
A Yes.

Q …being called into school every week and she considers that her son was hyperactive at that age. Dr Moses saw C again when he was six and had a half-an-hour talk with the mother and told her that she should see C again in one year’s time. Mother said that Dr Moses had seen C three times in four years.”

Then he expresses his surprise that not more has been done for the child by the local specialists?
A Yes.

Q Is that an accurate account of what you were telling Dr Cosgrove at the consultation about Dr Moses’ involvement with your child?
A Yes.

Q Can I go on, then, to the next letter which we see at the next divider, divider 5. It begins at page 2 and it is addressed to Dr Moses, dated 7 July 1999. If you look at the back page of that letter on page 4, Mrs C, you will see that a copy of it was apparently sent both to you and to Dr Rackham, your GP. Do you remember receiving a copy of that letter?
A Yes, I do.

Q Again, I just want to take you through it, please, and get your comments on it. In the third paragraph down, the paragraph beginning, “When I met Mr and Mrs C, C’s parents…” Do you have that?
A I think there are some notes mixed up on this one. I think I might have somebody else’s here.

Q Divider 5, page 2. Just to help you with that, again, can you turn to the end of that
letter, two pages on?
A  Yes.

Q  Do you see at the bottom, "c.c. Mr and Mrs C, Dr Rackham?"
A  Yes, that is right.

Q  Going back to the front of that letter, please, it is addressed to Dr Moses. Going down the page to about two-thirds of the way down, do you see the paragraph beginning, "When I met Mr and Mrs C"?
A  Yes.

Q  Dr Cosgrove says this:

"I was told that C had been attending St Cadoc’s Hospital five days per week since November 1998. I was also told that in that time, some six months you"

- that is Dr Moses -

"had seen C only once and that, furthermore, you told his parents that you were going to prescribe a sleeping tablet at night for C. This never happened! You neither prescribed this medication you had promised, nor did you explain to Mr and Mrs C why you had changed your mind and were no longer going to prescribe it."

Accurate or not as a report?
A  Yes.

Q  And then can we go over the page to Page 3 and about nearly halfway down to a paragraph beginning, "Why are you unhappy?", do you see that?
A  Yes.

Q  And Dr Cosgrove says:

"I feel sure that your unhappiness will turn to sheer joy and happiness when I tell you that within ten days C was very much better",

and this is after the prescription of Ritalin and Risperidone?
A  Yes.

Q

"He has ceased being aggressive and abusive, and his maternal grandmother has had him visit her three times over one weekend since starting the medication compared with no visits at all during the last eight months - six of which he was in your Children's Psychiatric Unit attending for five days per week!"
Is that an accurate account of what you were telling him?
A       Yes, it is. Yes.

"As a result of my intervention ..." (he goes on) "... Durands School have now changed their minds and are going to have him back - following a visit from a member of their staff. His mother says that her son is 'a lot better' and that there has been 'a great improvement'".

Again, is that accurate?
A       Yes, it is.

And what was the position with Durands School? Why had they decided not to have him?
A       Because I was basically advised to keep him home or he would be excluded. They could not cope with his behaviour, with his aggression, and it actually got that bad that C had actually injured a male member of staff. They had Health and Safety watching C's behaviour with apparatus. He would be told, "You can go two bars", and he would go eight, you know? There was just no -- and I had to keep him home.

Right. Going down to the bottom paragraph on that page, three lines in, and "You" is a reference to Dr Moses:

"You first saw C when he was 5 years old when he was not eating, was thin, was having frequent tempers and when the parents were being called into school on a weekly basis".

Now, is that an accurate account of what the position was when he was five years old?
A       Yes, it is. Yes.

"You made no diagnosis ..." (he goes on) "... and did nothing that actually resulted in alleviation of this child's malfunctioning".

Is that a correct account of what you were telling him?
A       That is right, yes.

"You saw him again when he was 6 years old and had one half-hour's talk with C's mother. There was a similar meeting when he was 7 years of age so that you had seen C and his mother three times in four years".

Again, is that what you were telling Dr Cosgrove?
That is right, yes.

And then over the page on Page 4:

"In 1998, he was not allowed to return to Caldicot St Mary's School because of his behaviour there during the previous academic year. In September 1998, he was expelled from Durand's Primary School after but one month there because of his violence to children and because he completely refused to do any of the work the teachers set. In November 1998, he was admitted under you to St Cadoc's".

Again, is that an accurate account of C's scholastic history?

Yes, it is. Yes.

Mrs C, can you just summarise for us the changes, if any, that occurred to your son, C, following his seeing and being prescribed medication by Dr Cosgrove?

Yes. Virtually straightaway, as soon as my son started taking the Risperidone and the Ritalin, on the day we returned from our very first appointment was the first night that my son had ever slept through the night - and, I mean, I am talking he was nearly seven - and I actually had to wake him in the morning which I had never, ever done before. I mean, he was always running wild after just a few hours sleep.

Following that he maintained for some seven years in mainstream school, but only as long as he had his medication. There was an incident where the medication for some reason was not at the school and, within two hours of him not having it, I was requested to go and fetch my son home from school.

To this day, C is still on medication via other specialists. He is now out of the area. He is still on medication, but he has maintained a very, very good seven years of a mainstream schooling which I think is a great achievement for C.

Prior to him going on to the medication, what were the prospects for him as far as his schooling was concerned?

The advice the other doctor had given me was - and this was in the April time - that come July when the children would break up from school that C would be far better off being in a Children's Home. That devastated me. My child was six-and-a-half and they wanted to push him off into care. There was nothing wrong with my care for my son. He just needed help and thankfully I got him that help.

MR MORRIS: Thank you, Mrs C. Wait there. There may be some more questions.

THE WITNESS: Okay.

Cross-examined by MR PEARCE:

Mrs C, could I make sure that I am understanding the sequence of this right?

Yes.
Q I am going to put to you what I understand to have been the sequence of the care and treatment that has been involved, relevant to your son's condition, and you tell me if I am right, if I am wrong or if you are not sure, if you will do?
A Uh-huh.

Q I want to start from this. That I suggest that Dr Moses first saw your son when he was five, nearly six?
A No.

Q Is that correct?
A No, definitely not.

Q When was it?
A He was, I would say, between the age of three-and-a-half -- he had an eating disorder. My son would eat nothing. He would scream and scream. You show him food and he would scream. That is when she very, very first seen C. Three-and-a-half/four.

Q Three-and-a-half?
A Uh-huh.

Q Could I ask you to look at Division 5 of that -- well, you are probably on Division 5 already?
A Yes.

Q A letter there from Dr Cosgrove to Dr Moses?
A Right, yes.

Q Do you see on the page that is numbered "3", typed number "3" at the bottom?
A Yes.

Q The bottom paragraph, second sentence:
"You first saw C when he was 5 years old when he was not eating"?

A No, no. He was about four.

Q About four?
A Three-and-a-half/four.

Q Right. Well, just so you are clear, I suggest that you are wrong about that and that he was five/nearly six when Dr Moses first saw him?
A No, definitely not, and I will tell you for why because I had actually separated with C's father that year and it was obviously a concern to me. It was quite a traumatic split for my son and he was definitely three-and-a-half to four. I would say four.

Q Right. Dealing with that split with C's father, it is right to say, is it not, that at least at that time contact between C and his father was problematic in that a lot of C's bad behaviour appeared to be linked with him seeing his father?
A Well, no, because C's behaviour was like it from the day he was born. It is just that, you know, I thought -- C is one of three children, the youngest of three. I had two boys a lot older.

Q Yes.
A A lot older.

B Q Yes.
A And I just thought, "I have got myself a naughty baby", as a parent would.

Q Yes. So, let me just read you these comments and ask you to comment on them?
A Uh-huh.

C "When he was nearly six when his mother ..."

I am sorry, this is what Dr Moses said in evidence, you see, and I want to see what you say about it:

"I had initially seen him when he was nearly six when his mother brought him with a variety of complaints that seemed to focus mostly around his behaviour when he had contact with his father from whom he was separated"?

A No.

Q You would not agree with that?
A No, I would not agree. No.

Q "The gist of that meeting was that this was a younger ..." (and there is no word here. It is from a transcript, but I think it means child I think) "... who was not too bad on the whole, but when he had met his natural father his behaviour was more difficult to manage"?

A My son was difficult to manage from day one. I would not blame anything. Having the contact with his father definitely was nothing to do with C's behaviour.

G Q Had his father been in the habit of putting his hands round your son's neck if he would not eat?
A Do you mind me asking where you got that information from?

Q Well, it has come from the medical records. Is that correct?
A Yes, it is correct. It happened on one occasion and access was stopped.

H Q And is it right to say that you thought that your son's reluctance to eat might relate
to that?
A  His reluctance, yes. Yes, I did.

Q  Yes. Now at that point on that first visit, whenever it was, Dr Moses - and I think we are agreed about this - made no psychiatric diagnosis?
A  No.

Q  And, indeed, she said that she did not think that your son needed psychiatric follow up?
A  No, she said she would see him in twelve months' time.

Q  Was not the second time when Dr Moses -- or, sorry, the second time that your son was referred to Dr Moses’ unit was on a re-referral from the General Practitioner about a year later?
A  Yes, because I had not had another appointment. She told me she would see him or send for him again in twelve months' time and it was then referred back to her.

Q  And on that occasion in fact you did not see Dr Moses, did you? You saw a more Junior Doctor?
A  I do not think so.

Q  Well, does this in any way assist your recollection? That the Junior Doctor eventually had a period of time off sick and was not able to see C, your son?
A  I thought that was Dr Moses?

Q  There was a doctor who was ill and who could not see you in any event, is that right?
A  Yes, there was.

Q  And that Dr Moses herself saw your son again in August of 1998?
A  Probably.

Q  For the second time, I suggest. And that what she was saying then was that she wanted to know how he was getting on at school? That it was the end of the summer holidays and that she wanted to see how he was at the beginning of the next school term and so she said, "I will see you again in a month's time in September - late September"?
A  I am not sure.

Q  And that the third time you saw Dr Moses, I suggest, was late September 1998?
A  I am not really sure.

Q  Might be?
A  Probably. I am not really sure.

Q  Right. And that having seen school reports Dr Moses felt that it was appropriate that your son be admitted as a day patient attending the school at St Cadoc's Hospital?
A  The school had told me not to send C to school any more. She had to do something, yes.
Q Well, that was her ---
A The school were advising me that my son was not to return to school. He had injured a male member of staff by one of his violent outbursts, when he threw the table and obviously hurt the teacher quite badly. They had done risk assessments at the school and it was felt that -- and I think you will find that -- so much has happened with my son that it is hard for me to put dates in and things to it.

Q I understand. I understand.
A But I am pretty sure that, if you check back in the records, it was via a telephone call made by myself that Dr Moses actually seen(sic) my son again and recommended that he would go into Pollards Well for a while.

Q Yes. She had asked, I suggest, that she had wanted to see those school records before she made a judgment in the autumn of 1998?
A You just stood there and said I went with reports and that she had seen the reports. I went armed with the reports. Of course she had seen the reports.

Q I have not said anything about reports other than to say that, when you attended in August 1998, she said she wanted to see the reports and wanted to see you again a month later?
A Uh-huh.

Q Does that ---
A She would have seen the reports of my son.

Q Yes. That sounds as though that would be right, does it?
A Well, not really, because my son was basically excluded from school and it was recommended that he would start Pollards Well School in the September.

Q Yes, and that was Dr Moses' recommendation?
A That he would start Pollards Well School.

Q Yes. She would have no choice, of course, in whether he was excluded from any other school?
A No, and she actually had no choice whether he would be excluded from Pollards Well as well but that happened too.

Q Yes. Well it was her decision to admit him to Pollards Well, was it not?
A Yes.

Q Now, then, there came a time - and I think it was about May 1999 - that you saw Dr Cosgrove?
A Uh-huh. Yes, it was.

Q And you have indicated how that came about?
A Yes.

Q How you came across his name. Now, did you go and see Dr Cosgrove in Bristol?
A I did, yes.
Q Yes. And when you went to see Dr Cosgrove, did the consultation with him take the form of him producing a questionnaire and asking you to complete it? A written document with tick boxes, do you recall that?
A No, I do not recall that. No.

Q Right. Do you think it did not happen, that there was no written questionnaire, or that there might have been and you have forgotten?
A There may well could have been. There could have been. I honestly cannot remember.

Q And he would have asked you questions, no doubt, about what was going on?
A He asked me lots of questions.

Q Approximately how long do you think that consultation lasted, Mrs C?
A Quite a few hours, because myself, my son's stepfather and C were all seen together; then myself and my husband were seen; and then he seen(sic) my son on his own and then he seen(sic) -- and I was quite amazed by this, because then he seen(sic) my son how he would react when I would not respond like this, you know? (Snaps her fingers) I was talking and I was getting the kicks and the thumps and the pulling on my hair and he was in the windows pulling the blinds down, you know, all the time. And Dr Cosgrove was being very patient, carrying on and, you know, talking to me and going through different things even though all this was going on, and C most definitely showed exactly what the problems were.

Q And you have indicated that subsequently the monitoring, the weight and the height measurement ---
A That is right.

Q --- and the blood pressure was done by a General Practitioner?
A Yes, that is right.

Q Did Dr Cosgrove carry out any physical examination on that visit in May 1999?
A Yes, yes.

Q What did he do?
A Weight, blood pressure, height, yes.

Q Right.
A All that was done there.

Q And by him? By Dr Cosgrove?
A Yes.

Q Not by a nurse?
A And there was a nurse there as well.

Q A nurse there as well?
A As well, yes.
A
Q How many further times did you meet Dr Cosgrove face to face?
A Face to face I would not have a clue. Quite a few times.

Q Approximately? I mean five, ten, 20?
A Five. Yes, probably five times.

B
Q Probably five?
A Yes.

Q And when was the last time you had any contact with Dr Cosgrove for clinical purposes - I do not mean anything to do with this case, but in terms of him caring for C - whether it was by letter, telephone or meeting him? Again, approximately? You may not recall precise dates.
A I would say approximately - oh, my mind's gone - 18 months or two years, probably.

Q 18 months?
A Two years.

D
Q So, perhaps mid-2002 perhaps?
A Yes, I would think so.

Q Right, okay. And then from 1999 until 2002, that period of approximately three years, did you have regular contact with Dr Cosgrove ---
A Yes, I did.

E
Q --- by one means or another?
A Yes, I did.

Q During that time, did the prescriptions of Ritalin and Risperidone change from time to time?
A Yes, they did. Yes.

Q Right. And was it Dr Cosgrove who was taking the initiative in saying, "Well, I think this dose needs to be adjusted - increased/decreased"?
A Yes, it would. Yes.

Q And then was your General Practitioner duly issuing a prescription on the basis of what Dr Cosgrove was saying?
A Not necessarily just on what Dr Cosgrove was saying, but I would take the prescription along and say, you know? And he would ask me what changes with my son, why did I -- you know, was I getting a problem. And, yes, I mean I would not say it was solely, you know?

Q No, I do not want to suggest that your GP was not independently bringing any judgment to bear, do not get me wrong, but was there ever an occasion when your GP did not follow a recommendation from Dr Cosgrove about a change in dose?
A No.
Q He always, in fact, followed the recommendation?
A Well, yes, because there would be a problem one way or another with my son, yes.

Q And I take it from what you said that throughout this period of time you had a confidence that Dr Cosgrove was, I was going to say meeting your son’s needs. That may be a fair way of putting it.
A He did.

Q In a way that other people such as Dr Moses had not.
A Yes, completely.

Q I take it from your attitude today that you still hold that view today.
A And I still hold that, very much so.

Q I understand. What was the highest dosage of Ritalin per day that your son received from Dr Cosgrove?
A I honestly cannot remember.

Q If we can think about it in terms of tablets, how many tablets a day do you think your son was on?
A Four.

Q Four?
A Yes.

Q Is that having tablets four times a day?
A Yes.

Q Was it one tablet each time or more than one tablet or, indeed, less than one tablet each time?
A One, yes, probably one of each.

Q One of each, Ritalin and Risperidone.
A Yes.

Q Do you ever recall there being a time when the dosage that your son received was more than one tablet at once?
A No. I do not think so. I cannot remember.

Q I appreciate it may be difficult to recall that. May I just refer you then to one or two parts of the letter from Dr Cosgrove to Dr Moses that we have been looking at. In this letter it is suggested that in the six month period from November 1998 to I think May 1999, which would be the period between your son starting at Pollards Well and Dr Cosgrove seeing him and therefore you ----
A Yes.

Q That Dr Moses had only seen your son once.
A That is right.
Q In fact, Dr Moses saw your son regularly during that period.
A No and actually I am quite annoyed about this, because I am just a normal parent trying to do the best by her child. I would turn up for these appointments that Dr Moses was supposed to be there and other people and I would turn up to having a nurse and a key worker giving me apologies, “Oh very sorry, she could not make it”, “Very sorry, she could not make it” and I used to get quite upset by it and think, “Well, I’ve got to make the effort. If I didn’t make the effort I would be a bad mother”, you know, if I made excuses repeatedly. She has seen my son once and on that meeting she promised me a sleeping draft because members of staff, key workers, nurses, were talking to my son and my son would say, “I watched so and so” and they would get the paper of the day before and say, “Well, that’s on at 3 o’clock in the morning, it didn’t finish until 5, oh, oh, yes”, you know, “you have got a problem, he isn’t sleeping, we will speak to the doctor”. She comes, “Yes, I will prescribe a sleeping draft”. I chased that sleeping draft for six months and never to this day have I ever, ever had a reason why she did not prescribe it ever given to me. My son did have a sleep problem. He would not sleep. He was up and hyperactive the whole time. I would not have got away with that.

Q What sleeping draft did she say she would prescribe?
A It began with a P, I think. I cannot remember the name.

Q I suggest to you that at no stage did Dr Moses -----
A Oh, she did!

Q Say that she was going to prescribe any sleeping tablet.
A 100% she did. She told me it was brought to her attention by not only myself, the staff.

Q Certainly she was aware, it was brought to her attention that there were sleeping problems.
A And she had told me at the only meeting she attended that she would prescribe a sleeping draft and that never ever came forward.

Q Dr Moses was seeing your son regularly on a weekly basis while he was at Pollards Well.
A No, no.

Q How do you know that, Mrs C? Were you present in Pollards Well all the time that your son was there?
A I was there a damn sight more than she was, that is for sure, and I was only a parent. Because of the feedback, because I was very involved in that school. I went up once a week and had lessons side by side with my son and, no, she was not that involved with my son. One meeting I am referring to. Out of six plus meetings she was supposed to attend she made one. Apologies.

Q Why do you think she was not at the other five meetings? Was it because she could not be bothered?
A I honestly do not think she could be, no, no. The only recommendation I had from her was to put C into care.
Q If Dr Moses was ----
A There was nothing wrong with him. Why then, if there was nothing wrong with my child, only a naughty boy that needed to go into care, why is he now still being treated, still taking medication and he is in a specialist school? He is not in care, he is in a specialist school. We are seven years on. If Dr Cosgrove had mistreated my son, why seven years on? Why? Dr Moses said there was nothing wrong with him, he was a naughty boy, put him into care.

THE CHAIRMAN: Mrs C, I know that these are difficult circumstances for you, but it would help us all if you would just pay attention to the questions being put by Mr Pearce and perhaps subsequently by Mr Morris and confine your replies to the substance of the question. I think it would help us.

MR PEARCE: When did Dr Moses say that your son should be put in care?
A April of that year where I then took my son privately. That is what forced my decision to take my son privately.

Q In what context did she say it?
A That there was nothing wrong with him, he was basically a very naughty child.

Q So she said there is nothing wrong with him, he is a very naughty child who needs to be in care or words to that effect.
A Yes.

Q I suggest that she never said that your son needed to be in care.
A What was the recommendation then?

Q Did she ever suggest that your son needed to be in care?
A Yes, she did, yes.

Q She said those words?
A Yes.

Q Could I ask you to have a look again at a letter from Dr Cosgrove to Dr Moses. Did you tell Dr Cosgrove that Dr Moses had said that your son should be in care?
A Yes.

Q Dr Cosgrove does not mention that in this letter. If you had said that to Dr Cosgrove, Dr Cosgrove would have put it in the letter, would he not?
A That is exactly and that is what resulted in me taking my child privately to see another doctor. I did not want my son going into care. I did not feel that was the right road and I still do not.

Q Mrs C, if anybody said that, and somebody may have said it ----
A It was.

Q But it was not Dr Moses.
A My son was due to finish school there in the July at Pollards Well and the
recommendation that was being forwarded in the meeting I had in the April and I only had it on a report (like I said, she did not attend any meetings anyway) and in that report it was stated that it was felt that C’s next placement should be of one in care. She felt that was my son’s problem, I think.

Q I suggest that is not what she said at any point.
A Okay. I was there.

Q It is apparent from this letter of Dr Cosgrove to Dr Moses that he feels angry about the care that had been provided to your son.
A Yes.

Q Did he express that kind of anger to you when you told him the background on that visit to Bristol in the May?
A Not an anger, but he could not see that my son could just be dismissed and, you know, not had any treatment or nothing was tried, that it was obvious from my son’s behaviour the whole time we were there that indeed there was a problem.

Q When you received this letter, the one to Dr Moses, a copy of it, what did you think about the letter? Did you think, “Well, Dr Cosgrove agrees with me. It is obvious that my son has not had proper care there”?
A Not so much that. I just felt that he was obviously, you know, explaining why I had taken C from the National Health, if you like. I brought him out from there. I just felt that he was throwing the case over.

Q But did you find that this letter confirmed your views that your son has been let down?
A Yes.

Q If I can pick up one or two matters, prior to that letter being sent, subsequent to you seeing Dr Cosgrove, Dr Moses indicated that it was no longer appropriate for her to treat your son, did she not?
A Yes.

Q Her explanation to you was that he was saying that he had ADHD and that that was an explanation for his behaviour and that that ran contrary to her approach.
A No. My son went to school. I had made it fully aware that I was taking my son privately to see somebody else.

Q Yes, I understand.
A And that he was going to be off on that particular day in May. My son went to school the next day and was told that was his last day there, as I had taken him privately then he was not allowed to see even the rest of the short period of time that he had left in school until the July, until they broke up for the summer. C could not even stay in that school until July. He was dismissed there and then. That was his last day and they invited him back for one day for him to say goodbye to his friends which was a week and a half or whatever later.

Q Dr Moses’ concern was that your son could not be both treated by Dr Cosgrove
and in her unit because it was two completely different approaches. Dr Cosgrove was making a diagnosis with which she did not agree.

A Agree with, that is right.

Q He was giving treatment with which she did not agree.
A Agree with, yes.

Q And that she felt that the diagnosis and the treatment were contrary to what she was trying to achieve in Pollards Well. She may have been right, she may have been wrong, Dr Cosgrove may have been right or may have been wrong, and I know you have your views on it, but I am just seeking to understand what the difference between them was that led to your son not going there any longer. It was Dr Moses saying it was not appropriate for him to continue “because what Dr Cosgrove is doing is not consistent with what I want to do”. Am I right in that?

A Yes.

Q It is right to say, is it not, that in the year 2002 your son’s behaviour again deteriorated significantly?
A A little bit, yes.

Q Sufficiently significant for your GP to refer him back to the Trust where Dr Moses works.
A Yes.

Q Dr Moses thought it was not appropriate that she should treat him.
A I would not have allowed her to treat him.

Q No, but there was a referral back.
A Yes. My son found it very hard to cope as my mother had died and he was quite upset by things and he had not been seen apart from with the GP then.

Q At that stage I suggest that your son was having three drugs - Ritalin, Risperidone and Clonidine.
A That is right.

Q The Ritalin at that stage, I suggest, was 40 milligrams a day. Just so you understand, it appears to be the case that Ritalin will come in 10 milligram tablets, so 40 milligrams a day would be four tablets, although in point of fact my understanding is that he would be having 1 ½ tablets at one time, 1 ½ tablets at another time and one tablet at another time, but anyway it was a total of four tablets daily and he was still seeing Dr Cosgrove at that stage.

A Not at that stage, no.

Q There is a letter I want to ask you to look at to see whether that is right that he was not still seeing Dr Cosgrove. I have to hand it over to you. I have not got any copies at the moment. We will have copies made if it is necessary in due course. Can I just ask you to have a look at this letter. (Same handed.) As I understand it, and we can run through the sequence, I think this is a letter from your general practitioner to Dr Moses’ unit in 2002.
A No, I had not actually been seeing Dr Cosgrove at that point.

Q The letter says you were seeing him, does it not?
A I know what the letter says, but, no. I will be honest with you, the only reason was because my Mum had died recently and she helped me fund my treatment for C. My appointments my Mum helped me pay for and I could not afford to continue on my own. That was the only reason.

B Was there a deterioration in your son’s behaviour?
A In C because his grandmother had passed away, yes, and they were very close. My mother was very, very young.

Q I do not want to intrude too much into the details of your private life. These experiences are intrusive enough as they are, I understand that, Mrs C, but was it the case that your mother’s death led you to stop going to see Dr Cosgrove because you could not afford it, is that what you are saying?
A That is right, yes.

Q I understand.
A But I knew that my son still needed to be seen as obviously there were problems and there are still problems now. He is still having treatment. He is still, you know, .....

MR MORRIS: I have no re-examination.

Questioned by THE COMMITTEE

E I have just the one question, Mrs C. You indicated that on the first occasion you attended Dr Cosgrove your son’s height, weight and blood pressure were taken.
A That is right, yes.

Q And that you had some five face to face consultations.
A Yes, I did.

F On the subsequent consultations were his height, weight and blood pressure taken?
A Yes.

Q They were taken?
A Yes.

G Was any comment passed on them?
A No, no, he was doing fine.

THE CHAIRMAN: Thank you very much. Mr Morris, do you want to come back?

MR MORRIS: No, thank you, sir.
THE CHAIRMAN: That concludes your evidence, Mrs C. Thank you very much for attending.

(The witness withdrew.)

THE CHAIRMAN: I am trying to work out an estimate of timing. Your witness is going to take another hour. It may be we will want a break at some stage. It may be better to take a break just now and then deal with the witness in one sitting.

MR MORRIS: Sir, yes.

THE CHAIRMAN: We will deal with it in one sitting?

MR MORRIS: Yes.

THE CHAIRMAN: We will take a short break just now and we will come back at 3.20.

(The Committee adjourned for a short time.)

MRS E Sworn
Examined by MR MORRIS:

Q I am going to call you Mrs E so as to safeguard your son’s anonymity. I just wonder if we could start, though, by you writing down on that blank piece of paper your full name together with the full name of your son? (Pause. Same handed to the Committee)

Q Mrs E, I think your son underwent treatment by the Oxfordshire Mental Health Care NHS Trust at the Warneford Hospital in Oxford?
A That is correct.

Q In the later part of the 1990s?
A That is correct.

Q In April 1999, you had made - you and your husband, I think, had made - a complaint to the Trust centring around their diagnosis of attention deficit hyperactivity disorder in your son, the length of time it took to reach that diagnosis, the subsequent care and treatment that was offered to him and the lack of support you felt had been given to yourselves to help you cope with his behaviour and condition?
A That is correct.

Q Did you have any assistance in formulating that complaint and presenting that complaint?
A Yes we did, with CHC, the Health Council, a lady called Val Garner.

Q Was that complaint put in in written form?
A Yes, they all were.

Q As a result of receiving that complaint, did anyone from the Trust see you?
A

We had several meetings with different people throughout the hospital, yes. Originally a Dr Oppenheimer saw us.

Q
Did there come a time when you saw a Wendy Samways?
A
Yes.

B

Q
Who, as we understand it, was at the time responsible for dealing with complaints to the Trust?
A
That is correct, yes.

Q
What was the upshot of the meeting you had with Mrs Samways of how the complaint should be progressed?
A
They would internally look through the paperwork to see if they could resolve the questions that I had raised locally within the NHS system and we still never had any satisfaction from that, so we were wanting to have the independent review.

Q
Was that agreed by Mrs Samways, that there should be an independent review?
A
I do not think she ever actually agreed to it, no. It was something that Val Garner had tried to push through.

D

Q
You talked about the fact that she was proposing that the record should be looked at internally?
A
Yes.

Q
Whom did you understand was going to conduct that review of records?
A
She did not actually say who but we did have a meeting with Dr Oppenheimer, Dr McDonald, who had been E’s clinician and again from that meeting we still had other concerns and the original concerns had not been met at all.

E

Q
Right. What happened next, then, as far as the complaint was concerned?

Q
We seemed to go from one to another to another, different doctor looking at them and Val Garner had actually written to the Ombudsman to see if they would get involved. In between times, Wendy Samways and Maria Dineen visited our home to push for an independent report on the situation.

F

Q
What did you understand by the independent report? How was that going to be done?
A
We were led to believe that it would be fair and that they would look into all the concerns that we had raised and they would if necessary criticise any of the NHS dealings and that then that would have answered in their terms their local issues, so it was another step forward for us, we were led to believe.

G

Q
Did you know at that stage who it was proposed would conduct that review?
A
At the meeting with Wendy Samways and Maria Dineen there were two names given and one of which was the lady who did the report.

H

Q
I think that was Dr Kenyon?
A
That is right.
Q: Did you agree to that review of records by Dr Kenyon?
A: Yes, I did.

Q: At that stage what was your understanding, if any, as to what further steps you could take if you were not satisfied with what Dr Kenyon reported?
A: We were not told any other procedures.

Q: At the time when you agreed to this procedure taking place, had you received any advice from the Community Health Council or from anyone else?
A: Not at that point. It was not until afterwards that we had agreed to the review that, because our Health Council lady was on holiday but when she returned she said she would not have actually suggested we go down that route.

Q: Had you at that stage met and seen Dr Cosgrove by the time this stage had been reached?
A: Oh, yes. Yes.

Q: Did you discuss the proposed review with him?
A: Yes, I did.

Q: What was his view?
A: Again, he did not think it was in our best interests to have gone down that line.

Q: I would like you, please, to look at a letter he wrote. In front of you, you should have a bundle of documents headed C8. Could you look, please, at divider 7 of that? On the first page there is a letter from Mrs Samways to Dr Cosgrove asking him to provide her with copies of any medical records he might hold regarding your son and mentioning that the Trust is currently reviewing the management of your son’s care. Over the page, there is Dr Cosgrove’s response to that request, dated 3 October 2000. Do you have that?
A: Yes.

Q: If you look at the end of that letter you will notice that a copy of it was apparently sent to you?
A: Yes.

Q: And your husband. Can you confirm having received a copy of that letter?
A: Yes.

Q: He says in that letter that he is unwilling to agree to the request to disclose your son’s records to the enquiry and he sets out his reasoning:

“I do not believe that the independent expert will be truly independent nor sufficiently knowledgeable concerning the treatment I have given to E subsequent to my taking over his care from Dr McDonald. I am concerned that I am being drawn into a process which in the end will whitewash the circumstances of E’s inadequate care given by an employee of your Trust. It seems to me inevitable
the Trust will come to a final decision which first and foremost will ensure that the Trust cannot be sued by Mr and Mrs E with regard to the care of their son.”

Did you approve or disapprove or have any views on his decision not to disclose your son’s records to that enquiry?

A  I approved. I knew that Dr Cosgrove was actually going to write and say that he would refuse as well.

Q  You knew that in advance?
A  Yes. Before the letter, yes.

Q  What were your views, please, when you received that letter on his assertions that, first of all, your son had been given inadequate care by the Trust, that that investigation might end in a whitewash of such inadequate care?
A  I agreed. I agreed with the statement there.

Q  That the investigation was programmed to ensure the Trust was not criticised at all or only criticised in a minor way?
A  Certainly when we received the report back they were not.

Q  Obviously you did receive the report from Dr Kenyon. What was your view of that report and its assessment of the care that had been given to your son by the Trust?
A  It was a whitewash. They were vindicated. I do not think that they were given the full and correct information in the first place and certainly from the information they were given, they had every reason to say that the NHS did a wonderful job.

Q  That review by Dr Kenyon involved her reviewing the medical records. Is that correct?
A  I am not quite sure if it was the medical records but certainly some of the communications from the Trust. I am not quite sure whether she was given E’s full records or not.

Q  She did not speak to you. Is that correct?
A  No.

Q  Can you help us, please, with your assessment from your perspective as E’s mother, of the treatment that your son received at the hands of Dr Cosgrove?
A  It was a complete turn around for my son at that point. He had declined emotionally and behaviourally very severely and when Dr Cosgrove took over, he then turned E around emotionally and behaviourally.

Q  What was his diagnosis?
A  That he had attention deficit disorder, that he had Tourette’s and also oppositional defiant disorder.

Q  What medication did he prescribe for him?
A  He had Ritalin, pimozide and Risperidone.
Q The pimozide was for what condition?
A Tourette’s.

Q Was there any monitoring of your son’s condition after the prescription of those drugs?
A Yes. The GP has regular monitoring of my son.

B Q What form did that monitoring take?
A Weight, height, blood pressure.

Q Did you have any further contact with Dr Cosgrove after the initial consultation and assessment and diagnosis?
A Yes, very regular.

C Q Was that by telephone, or by meeting, or...?
A Both.

Q Both.
A We have had telephones and also meetings with Dr Cosgrove.

MR MORRIS: Yes, if you would wait there, please.

Cross-examined by MR PEARCE:

Q Could I ask you a little about the complaints process first, please, Mrs E. Am I right in understanding that this is the only time that you have made a complaint in respect of medical treatment?
A Yes, it is.

Q Yes. So, would it be fair to say that you had limited knowledge of the procedures involved?
A Very limited, yes.

Q Yes. Now before you made this complaint I think your son had been treated at the Trust for some little time, is that right?
A About a year.

Q About a year?
A Yes.

Q And ultimately a diagnosis of ADHD had been made?
A It had been made, yes.

Q Although it had not been made you thought as early as you thought it might have been, is that right?
A I thought it could have been made a bit earlier, yes.

H Q Yes, I understand. Yes. And I appreciate you had other complaints.
A Yes.
Q: I am not at the moment too concerned with the detail of the complaints, but just to understand the position.
A: Yes.

Q: So, you made this complaint and you had assistance from the appropriate people who are there to help ---
A: Yes.

Q: --- those such as yourself who have complaints about medical treatment?
A: Yes.

Q: And ultimately you had this meeting, or you had as you indicated a number of meetings, both with doctors - Dr Oppenheim and Dr McDonald?
A: Yes.

Q: But also with the administrators, if I can call them that, such as Wendy Samways?
A: Yes.

Q: And is it fair to say this, that initially it was being suggested from the Trust's side that they would carry out an Internal Review and that what you wanted was an Independent Review?
A: I do not think at that point we were wanting an Independent Review in the early stages. It was that all the way along we had wanted explanations of why things had happened.

Q: I understand, but were they -- well, perhaps I am getting ahead of myself. Did there come a time when you were not getting adequate explanations and, therefore, you felt there should be an Independent Review?
A: Yes.

Q: And that was why Mrs Samways or Miss Samways came to see you, or saw you, to discuss there being such a review?
A: No, she came to see us in the house for the report to Dr Kenyon.

Q: Right. I am sorry, the report of Dr Kenyon?
A: Well, for Dr Kenyon for her to do the independent report.

Q: Oh, I see. Yes. Well, we may be at slight cross-purposes. At that visit, when Miss Samways attended at your house, her purpose was with a view to asking you if you agreed to Dr Kenyon or the other named person carrying out a review of the documentation?
A: Yes.

Q: Yes. And do I correctly understand it that from your point of view at that stage, with the advice you had received, that seemed like a good way forward because it was an independent person looking at the papers rather than somebody from within the Trust?
A: That is what we were led to believe from the Trust, yes.
Q  Yes, yes. And, therefore, you agreed to that review going ahead and to Dr Kenyon being the person carrying out the review?
A  Yes.

Q  Is it not the case that Miss Samways made clear to you that, whatever the outcome of that review, it was open to you to proceed thereafter through the NHS complaints procedure?
A  No.

Q  Did she talk about trying to resolve the matter locally before other procedures were followed?
A  Not that I can recall, no.

Q  Right. But you would only have a fairly vague sense of what the procedures were?
A  Definitely, yes.

Q  Yes, I understand that. Now Dr Cosgrove's letter that we have looked at came, as I understand it, after that visit from Miss Samways?
A  Yes.

Q  But before you received Dr Kenyon's report?
A  Yes.

Q  But in the meantime, between the Miss Samways visit and Dr Cosgrove's letter, you had spoken to Dr Cosgrove?
A  Yes.

Q  And told him about the Independent Review?
A  Yes.

Q  Did what Dr Cosgrove have to say to you about that reflect the kind of things that he has said in this letter as to why you should not agree to it?
A  Well, I had already spoken to Val Garner ---

Q  Yes?
A  --- before I spoke to Dr Cosgrove.

Q  Yes?
A  And so I had already formed the opinion that it was not going to be to our best advantage to have gone for the report.

Q  And what was Dr Cosgrove's view? Why did he think you should not go for that?
A  Again, because he thought it would be in the Trust's favour and that it would not do us and our case any particular use at all.

Q  Right. Why was he saying it would be in the Trust's favour?
A  Well he did not really go into an awful depth about why, but certainly that, you know, from what we were led to believe from the Health Council that they would use the time to vindicate themselves, and Dr Cosgrove did agree with that point.
So, Dr Cosgrove was saying that he thought that the report would, what, result in Dr Kenyon vindicating the Trust?

Yes.

Right. And how? How was that going to come about, as you understood what Dr Cosgrove was saying? Was Dr Kenyon not going to be shown relevant documents, or was she going to express a biased opinion in favour of the Trust? What was your understanding about?

Possibly that, you know, it would be certain parts of information given and not the full side of the things that we were asking for.

Right.

So, they would pick and choose their paperwork.

Right. So, that the Trust might not disclose everything that was relevant?

Yes.

Right. You see, in this letter he says, "The expert will not be sufficiently independent to do justice to the case"?

Yes.

Was that a view he expressed to you, that Dr Kenyon would not be sufficiently independent?

He did not personally, no, but I did actually speak to the ADHD Helpline who was quite surprised that this particular lady had been picked for being a specialist in this area.

Well there is more than one point there, is there not? One is whether she is sufficiently specialised in the area which is another point that Dr Cosgrove makes, but one is whether she is sufficiently independent. Now, Dr Cosgrove is expressing the view in the letter that she is not sufficiently independent. Did he express that view to you?

No, no. Not in that sense, no.

Right.

But, you know, we have spoken about that and obviously no-one is going to criticise another psychiatrist if there is ever a chance that they are going to meet. So, in that sense, you know, I had already ascertained the fact myself that she possibly would not be as independent as we would have liked.

How would you get a more independent psychiatrist, just in point of fact?

I do not know.

No. How had you ascertained that she was not as independent as you might have liked?

Through the Helpline that they have a wide knowledge -- well they are not actually functioning now, but they had a wide knowledge of different doctors on who they had dealings with who are not on a bad list, but certainly they would know whether they were a good choice to go and see or not.
Q Well, can I explore that a little bit further and see what you have to comment on this. We have heard evidence in this case that amongst psychiatrists there is a range of opinions, firstly as to making the diagnosis of ADHD and secondly as to prescribing drugs for it, and those opinions are as I understand it essentially these. Some people would - some psychiatrists would - only diagnose ADHD in a very small number of cases and would have very tight definitions, and some other psychiatrists would have a rather wider definition of what amounted to ADHD. So, that is the diagnosis. And in terms of treatment some psychiatrists would be very reluctant indeed to prescribe drugs and would look to behavioural psychological type therapies, if you like, and other psychiatrists would believe that medication was a primary choice - one of the first things you should look to - in those ranges of opinion?

A Right.

Q Were you aware, through speaking to the ADHD Helpline or speaking to Dr Cosgrove, that there were differences of opinions ---

A Yes.

Q --- along those lines?

A Yes.

Q And what you were being told, did it amount to this? That Dr Kenyon's views were not at the same part of that range or that spectrum of opinion as Dr Cosgrove's, for example?

A Well, no, because I mean when I had spoken to the Helpline they had basically said that she had been in and out of practice for the last five years when she had been having children.

Q Right.

A And so her actual knowledge at that particular time, with all the new drugs or whatever, she would not have been as up-to-date as maybe some other doctor.

Q So, she might be less expert?

A Yes, yes.

Q Yes. But, in terms of independence, what were you told that led you to believe that she might not be as independent as you would like?

A In that sense, nothing. Just the sheer fact that, because again she is an NHS doctor, they would generally watch each other's back if you like.

Q Right. So, that is the point that essentially any NHS doctor would be a problem because they might be meeting in NHS circles and might show less independence than...?

A Yes. In that sense, yes.

Q When you spoke to Dr Cosgrove about this, did he have anything to say about his experience of these matters in comparison to, for example, Dr Kenyon? His experience of dealing with treating children with ADHD?

A No, he did not say that she was a bad doctor in any sense and, you know, that he was a better doctor.
Q Right.
A Not in that sense, no.

Q I am not suggesting he said she was a bad doctor actually, but I am suggesting to you or asking you whether he said that he was a better doctor?
A No.

Q No, okay. Or a more experienced doctor in this field?
A No.

Q Now you had, I think as we see from Page 1 of this division of that bundle, signed an authorisation for Dr Cosgrove to release records for the purpose of this investigation, is that correct?
A That is right. The day that they came to our house.

Q Yes. And you had not told Miss Samways that you no longer authorised that release, is that correct?
A That is correct, yes.

Q And, indeed, you never said to her, "I have changed my mind"?
A No.

Q "I do not want you to have the records from Dr Cosgrove"?
A No.

Q And you never said to her, "I have changed my mind. I do not want this review to proceed"?
A No.

Q No.
A As far as I was led to believe it was all systems go.

Q Yes. When you received this letter from Dr Cosgrove, then, were you surprised by what he had to say in terms of his unwillingness to agree to the release of his records?
A No, because I had already known beforehand that he was reluctant to.

Q Right. Did you say to him, "Well I think you ought to, Dr Cosgrove, because we want to see how this review goes"?
A No.

Q "I would like you to co-operate with it"?
A No.

Q Were you keen for him to co-operate with the review?
A No.

Q Was it going to help your cause if he did not co-operate?
A If he what, sorry?
Q Was it going to help your cause if he did not co-operate?
A I do not think it had any impact at all, to be quite honest.

Q Were you surprised what Dr Cosgrove was saying about the expert being not sufficiently independent to do justice to the case?
A No, I was not surprised. No.

Q Or that she was not sufficiently knowledgeable or experienced?
A No.

Q Were you surprised when he said that he is probably the most experienced specialist in the United Kingdom in the use of Risperidone?
A No, I am not surprised. No.

Q Were you surprised when he said that you will not find an expert who will be able to do justice to your son's case?
A No, I was not surprised at that either. No.

Q Were you surprised when he said that he believed that this would be a cover-up of the care that your son had received?
A Again, no, I was not surprised.

Q They are fairly strong words though, are they not?
A I think he feels very deeply about his patients.

Q Oh, I appreciate that, but this goes rather beyond his feelings about his patients. This is his feelings about how other medics and those involved in the medical sphere respond to criticisms about them and investigate those criticisms?
A I mean that is really not for me to say on what he believes, but I do not get that impression that he thinks he is above anybody else.

Q And when Dr Cosgrove says in his letter, and no doubt you recall this passage, "You should be asking me for my expert opinion on the matter and not just for the notes", did it strike you that it might be a good idea to get Dr Cosgrove's expert opinion?
A I think it possibly would have been in the Trust's best interests to have done that but, again, that would have criticised their handling of E and so they were I do not think particularly interested.

Q Now, you received this report subsequently from Dr Kenyon?
A Yes.

Q And it did not uphold your complaints, as I understand it?
A No.

Q Did you make any further complaints or take matters any further thereafter?
A Yes, we had to go back to then the Health Council and through them we then went to a solicitor.

Q Right. And did that matter proceed? I do not particularly want to know the details
of it, but did that matter proceed - you going to see a solicitor?
A  Yes, it did.

Q  To an action?
A  Not to being sued, no.

Q  I see. Did you obtain an adequate resolution of your dispute with the Trust?
A  Yes, we did.

Q  I am glad to hear that. If I can ask you about Dr Cosgrove's treatment of your son, was it around this time that he had first seen him? Around -- well, this letter is dated 3 October 2000. When had Dr Cosgrove first seen your son?
A  He saw him in the June.

Q  June of 2000?
A  Yes.

Q  And has he seen him, or when did he last see him? Actually see him?
A  A face to face visit?

Q  Yes?
A  That would have been 2002, I think.

Q  Right, right.
A  The late part of 2002.

Q  I am sorry, which part of 2002?
A  The late part of 2002 I would have said, yes.

Q  The late part of 2002. So, he would have seen him over a period of two years or slightly longer?
A  Yes.

Q  When was the last time you had telephone contact for the purpose of your son's treatment?
A  That was before - just before - Christmas.

Q  Just before Christmas of last year?
A  Yes.

Q  Of last year, yes?
A  Yes. 2003, yes.

Q  Right. During the period then from when Dr Cosgrove first saw your son to the last time that he actually saw him face to face, on approximately how many occasions did he see your son?
A  Only about three or four, I think, over the whole period.

Q  I see. And approximately how many telephone consultations did you have in the
period between first seeing Dr Cosgrove and December 2003?
A       That was quite a lot.

Q       Approximately? I mean are we talking once a month, once in three months, once in six months, or...?
A       In the early days it was once every month to six weeks.

B
Q       Right.
A       And the most we ever felt confident being without was about three months.

Q       I understand. And during that period you have indicated that your General Practitioner, I think, was involved in monitoring?
A       Yes. Oh, yes.

C
Q       By measurements and such like?
A       Yes.

Q       I understand. Can I ask you about prescriptions of medication during that period. You have mentioned those three drugs. I am concerned first of all, or primarily I think, with Ritalin. Has the prescription varied during that period from Dr Cosgrove first seeing your son until December of last year when he last had a telephone conversation?
A       Do you mean has it been increased?

Q       Well, up or down?
A       Yes.

Q       It has changed?
A       Yes.

E
Q       Has it changed a number of times?
A       Yes.

Q       Both up and down?
A       Yes.

F
Q       What is the maximum dosage that your son has received during that period?
A       On the Ritalin?

Q       On Ritalin, yes?
A       He takes five of those a day.

G
Q       Five single tablets a day?
A       Yes.

Q       Is that the highest he has had? He has never had higher than that.
A       Yes.

H
Q       Risperidone, what about that? What is the maximum dosage of Risperidone?
A       He is on seven of those a day.
MR MORRIS: I have no re-examination, sir.

Questioned by THE COMMITTEE

THE CHAIRMAN: I have just got one question and it is to clarify a point raised by Mr Pearce. You authorised the release of the records held by Dr Cosgrove and you gave Wendy Samways that authorisation.
A Yes.

Q As I understand it from the question that Mr Pearce put, that authorisation was never formally withdrawn. There is no letter which indicates that you cancelled that authorisation.
A No.

Q When Dr Cosgrove decided not to release the records, was that his decision or a shared decision?
A It was shared.

Q But you never intimated in writing to anyone that you were formally withdrawing your authorisation to release these records.
A No, I thought that Dr Cosgrove’s letter would actually end the question about them having his records.

Q The letter that has been referred to, the October 2000 letter where Dr Cosgrove is indicating he is not releasing the records, was that letter stimulated by a telephone consultation or a face to face consultation?
A No, it was the telephone.

Q Who initiated the telephone call?
A It just happened to fall in with another appointment, a previous appointment arranged, so I did not need to get hold of him for that purpose.

Q So it was Dr Cosgrove who telephoned you.
A Yes, further obviously for my son.

Q Can you recall whether the issue of the release of records during that telephone call was first raised by you or by Dr Cosgrove?
A I believe it was from me, that I had actually said that we had had a visit from the Trust and that they were going to do an independent report and that they had asked Dr Cosgrove for his records.

Q And that you were having second thoughts about his records being made available.
A Not so much the records being available, but certainly going up, you know. We had already spoken to the health council that suggested that that the review was a bad idea and Dr Cosgrove then supported the idea and said that he would refuse to send the records.
Q You did not provide Dr Cosgrove with a written statement saying that he was not to release these records?
A No.

THE CHAIRMAN: Thank you very much. I do not think there are any further questions from this end of the table. Mr Morris, do you want to come back?

MR MORRIS: No, thank you, sir.

THE CHAIRMAN: That concludes your evidence. All that remains is for me to thank you for coming to assist us.
A Thank you.

(The witness withdrew.)

THE CHAIRMAN: Does that conclude the business for today?

MR PEARCE: I think it does.

THE CHAIRMAN: Are there any housekeeping issues that need to be raised?

MR PEARCE: Not from my point of view, sir, no.

THE CHAIRMAN: Is 9.30 tomorrow a suitable housekeeping arrangement?

MR PEARCE: Yes.

THE CHAIRMAN: Agreed.

(The Committee adjourned until 9.30 on Wednesday 16 June 2004.)
MR D MORRIS, of Counsel, instructed by Messrs RadcliffesLeBrasseur, appeared on behalf of Dr Cosgrove, who was not present.

MR R PEARCE, of Counsel, instructed by Messrs Field Fisher Waterhouse, appeared on behalf of the Council.
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THE CHAIRMAN: Good morning. Mr Pearce, is it over to you now?

MR PEARCE: It is, sir. I recall Professor Taylor, please.

ERIC TAYLOR Recalled

THE CHAIRMAN: I will just remind Professor Taylor for the record that he continues to be under oath.

THE WITNESS: Indeed.

MR PEARCE: I am obliged for that indication, sir.

Examined by MR PEARCE (continued)

Q Professor Taylor, we had I think reached a point at which you had dealt with the generality, if I can put it that way, in terms of background in respect of the condition of ADHD, in respect of prescribing medication such as Ritalin, in respect of the debate between such a prescription on the one hand and other forms of therapy on the other hand, and as to what you had to say in general terms in respect of monitoring of medication and appropriate examination before medication was commenced.

Could I ask you then if we could start to turn to the particularity of the cases and, if we could deal with the patients in order, Patient A. Now just to deal with a matter in respect of Patient A, is it in fact correct that since the matters with which we are concerned with in the charges in this case Patient A has been referred to you?

A Yes, that is correct. He was not referred for treatment. He was referred to the care of Dr Margaret Thompson, who is a specialist in Southampton, and she asked for another opinion from me because of the unusual doses that he was on.

Q Right.

A So, I saw him for a second opinion.

Q Yes. And you are aware that on behalf of Dr Cosgrove a request was made for the records from you?

A Yes.

Q Some records have been provided and I think copies are with the Doctor. Just so that we understand those records, I think you have looked through them this morning and confirm that they comprise part of but not the entirety of what will be within your files?

A Yes, that is correct. I was not in the hospital yesterday and so I could not supervise the actual files. What they have sent I think is the essence of the files; that is to say that when the referral comes we make a detailed report and that is what you have got. There would also be that there would be a lot of documentation that has been sent to us, from a lot of other sources, which I think you will probably already have ---

Q Yes.

A --- through other routes, and then there would be the correspondence that we sent
out but that would be the essential part of the correspondence.

Q       I understand. I understand. Well, I will not ask you any more about that now.
A       Yes.

Q       It is just so that we understand the position.
A       Yes.

Q       Now, in respect of Patient A, the case that we bring - this is not admitted, but the case that we bring - is that from May 1996 Dr Cosgrove was prescribing to this patient Ritalin and that the dosage increased so that by May of 1998 it was 100 mgs of Ritalin a day and by May of 1999 it was 130 mgs of Ritalin a day. In addition, that from July 1996 Dr Cosgrove prescribed Risperidone and that from November 1998 he prescribed clonidine.

Now, what I want to ask you in the light of those prescriptions is in respect of what monitoring of this patient was appropriate. In the first place, if Dr Cosgrove did not see the patient between May 1996 and May 1999, is that in your view appropriate?
A       It would only be appropriate if there were adequate shared care arrangements in place.

Q       Right. And what would be an adequate shared care arrangement here?
A       Well, there are several monitoring considerations that would come in with this. First of all there would be the ordinary level of monitoring that you always do, or try to do, if the children were taking stimulant medication - that is to say the regular checks on growth and the regular checks on blood pressure - all of which can be done in primary care, or by a paediatrician.

Q       Yes.

A       Then, especially because he is on high doses, you need the subtler problems - the more psychological problems - that can appear, and I think I mentioned when I was giving evidence before the possibility of hallucinations and the possibility that attention can become too constricted - too perseverative - and the child can give the impression of concentrating but in fact be frozen on the task.

Q       Yes?

A       And the appearance, or the possible appearance, of depression and mood changes as well.

Q       Yes?

A       And all those things I think are such reasons that you need really either a psychiatrist or a very specially trained paediatrician to be the person who is assessing that kind of change.

And then there are the issues of monitoring that come from the combination of medications, and I think that particularly I would be putting the cardiovascular issues here.

Q       Yes?
Because he is on a combination of drugs that do have an effect on the heart. The clonidine lowers the blood pressure, the Risperidone lowers the blood pressure, the Risperidone can alter intracardiac conduction and the Ritalin can increase the heart rate. And so those things together mean that I would have seen a need for cardiac monitoring as well, which I think a paediatrician would probably be able to do though they might not be aware of the issues of the interactions between these drugs.

Now we are and I think you are aware that a paediatrician, Dr Holme, was involved in seeing this patient during this period in the late 1990s?

Yes, that is right.

And I think, so that we know, you have read Witness Statements that were prepared in this action?

Yes.

And so you know something of what people have said in the background?

Yes, yes.

Could I refer you please to Exhibit C12, which I hope is to your right, and Page 93 of that exhibit? You will see typed numbers at the bottom. This apparently is a letter from Dr Holme to Patient A's General Practitioner, and it follows I think a referral or an issue being raised by Dr Vereker, a child psychiatrist, about provision of Ritalin therapy and also about the referral of Patient A to Dr Cosgrove. In the fourth paragraph of that letter do you see this:

"Margaret Vereker joined me for a major part of the consultation and at the end we agreed that the management of the Ritalin dosage would be left to Dr Cosgrove at The Bristol Priority Clinic. Input on behavioural and cognitive training would remain with Mrs Corrigan, the Child Care Specialist"?

Yes.

And I think we see at the bottom that this letter was copied to amongst other people Dr Cosgrove?

Yes.

In that situation, the situation of Dr Holme having said that, what if any monitoring should Dr Cosgrove have undertaken in your view?

Well, this I think is a point where the child is fairly stable on medication and so the -- I mean in the early stages of medication, of course, you need to be checking more often, like monthly, on blood pressure and weight.

Right?

But I think what I would have expected then would be, I think, a three-monthly check on all those main issues that I was indicating before in monitoring.

That is to say ECG, blood pressure, pulse rate and growth and mental status.
A  Q  Right. And who should have been doing that?
A  Well, under those circumstances Dr Cosgrove should have been doing it ---

Q  Yes.
A  --- or else renegotiating the arrangement about what the shared care practice is.

Q  Yes. Now if I refer you, please, to slightly further on in that bundle, let me take by way of example Page 125. Now I think you will see at the bottom of Page 125, do you see the date of 13 November 1996?
A  Yes.

Q  This I think Dr Holme indicated in his evidence was a clinical note that he prepared following a clinic on that day?
A  Yes.

Q  You will see there is reference to weight and height, there is reference to the levels of Ritalin and Risperidone that are being prescribed:

"Functioning well. Attention at a level at which he can function. Can control impulsivity within limits. Concentrates unaided ten minutes. Had a good holiday",

and then the top of the next page:

"BP..." (blood pressure presumably) "... 100/70. Growth ...",

with a tick, presumably meaning okay, and then "6/12" I think indicating that he should be seen again in six months.

If I can then refer you to Page 88, and I am sorry to take you around the documents like this Professor Taylor, this is a letter typed on 19 November following that clinic:

"Dear Christopher ..." (that is the GP) "... A is making good progress and his attention is at a level at which he can function. He is able to control his impulsivity within certain limits and can concentrate unaided for about up to 10 minutes. His blood pressure today was 100/70 and his growth satisfactory with his weight at 23.7 kgs being on the 9th centile and his height at 124 cms between the 2nd and the 9th. His drug treatment at the moment consists of a total of 60 mgs of Ritalin a day plus, 1/2 tablet bd of Risperidone.

The Maudsley Hospital Guidelines suggest that we should check a full blood count at least annually on children who take Ritalin and I will arrange this the next time we meet in six months. A's Fragile X screen was negative by the way",

and we see at the bottom that that letter was copied to Cosgrove. Was it sufficient
monitoring, for the purposes that you indicate, that Dr Cosgrove should rely upon Dr Holme seeing this patient in a clinic and providing information along the lines of this letter?

A Only for some purposes, I think. I think from the point of view of the physical effects I think that is perfectly reasonable. At that point the drug treatment is within the ordinary range of medication doses. I do not think it would have been necessary to do an ECG at that point. He is not on the clonidine at that point. And so from the point of view of the physical monitoring I think that is fine, but of course that does not tell the prescriber anything about the mental state of the child.

Q No.

A And of course it is the mental state of the child against which you are wanting to titrate the effects of the medication, and in particular knowing how things are happening at school and reports from the school are pretty crucial.

Q Yes, right. And does adequate monitoring of this kind require Professor (sic) Cosgrove then to see the patient from time to time?

A It requires him to get information about the child. It requires him to get the reports from the school, for instance ---

Q Yes.

A --- and knowledge of that. But if it were the case that the situation had changed and that Dr Holme was then providing the physical monitoring, as he is doing, then at that dose level I think that is reasonable.

Q Right. What about at higher dose levels when we get to 100 and 100 plus?

A Then I think personal contact would be absolutely essential.

Q Right. Now, you mention clonidine. After the prescription of clonidine, then, what further was required by way of monitoring?

A Well clonidine, because it is a blood pressure lowering drug among other things - it is a sedative drug - you need to be clear that the introduction of it is not sedating the patient and you also need to be quite clear that it is being taken in a regular fashion because, if you miss doses, then you can get a rebound hypertension. The blood pressure which is usually kept low by the drug ---

Q Yes?

A --- can rebound and become quite worryingly high. So, it is essential that you ensure and maintain that the drug is being given in an absolutely regular fashion.

Q Yes.

A And so the combination of that and the clonidine, I would have thought that that called for monthly monitoring by a person who knows what they are looking for.

Q Yes. Now in a patient who is prescribed Clonidine what, if any, warning should be given to the patient, or in the case of a child, patient’s parents about any dangers associated with Clonidine?
The main one is the need to take it regularly, that is to say do not miss doses. If you cannot take it regularly then really it is better not to embark upon the treatment because the hazards of it are, I think, essentially the hazards of blood pressure rebound.

Of hypertension? Of hypertension. Some people would say that you need almost to have ECG monitoring if you were doing the combination of Clonidine with Ritalin. This comes from a paper that reported four sudden deaths in children who were taking the combination of Clonidine and Ritalin. However, it would not be consensus on that. Not everybody would do ECGs with children on the combination. I think it would represent cautious practice.

Does the prescription of Risperidone have any bearing on what is appropriate in terms of monitoring here? Risperidone brings in a new class of problems. It can reduce the blood pressure, though in these doses it is not very likely, but, nevertheless, you need blood pressure monitoring during the early stages of introducing Risperidone. Our biggest concerns about it are probably metabolic, that is to say that it can induce greater obesity and we have started to see cases of type 2 diabetes appearing in children who have been given Risperidone. It can cause hyperlipidaemia, sorry, it can cause an excess of fats in the blood and it can cause an excessive secretion of the hormone prolactin which can make the breasts grow and lactate, which is an unpleasant effect, especially for young men and has other physical hazards in the long-term. So I think there is also the potential with Risperidone of having the same kinds of adverse effect that happen if you people with psychosis start on the major tranquilisers, which, of course, this is. Though it is uncommon you can get a sudden movement disorders, you can get sudden dystonia appearing, where the muscles go stiff. People need to be warned about the possibility of that in case they needed to take the antidote for it. Then there is the remote but described possibility the neuroleptic malignant syndrome, which is a condition of very high fever, muscular rigidity, it is a medical emergency, it is a very serious but rare complication. People on Risperidone should be warned if they do run an unexplained fever they should go to their doctor.

Does that have a bearing on what review is appropriate on the part of Dr Cosgrove? Not especially because those things are unpredictable. It certainly means that somebody who is capable needs to be checking the neurological status to make sure there is not a syndrome developing of abnormal motor movements or motor tone. But the big danger of the malignant syndrome is not a thing you can predict. It is more of a question of warning people to report rapid if there is a fever sign. And I would have expected to take an ECG in the combination of those drugs.

In terms of dosage increases, as and when they have occurred, and I am talking here about dosages increases to figures above 60 mgs a day, what do you say about the need for Dr Cosgrove, the treating psychiatrist, to have seen the patient when such increases of dosage took place? I think they should have been seen by a psychiatrist, preferably by the prescribing psychiatrist when high doses above the normal ranges have been introduced.
Q Why is that?
A Because of the possibility appearing of the hazards, especially the psychological hazards of depression, of hallucinations, of excessive attention which are things that may not be reported to you by the familiar, they may not even be reported by the teacher.

Q Yes. What about the relevance of alternative therapies? One takes it that an adjustment of dosage upwards will reflect the fact that there is seen to be insufficient response to the existing dosage. To what extent is review required to consider whether alternative therapies may be appropriate?
A Yes, this is the issue of whether a specialist psychological therapy and behaviour therapy in particular should be introduced. It seems from the large and important American trial, which think I referred to last week, that if behaviour therapy is given at the same time then the necessary dose of medication is reduced. That is in that trial the necessary dose without behaviour therapy was something like 35 mgs a day and with it it came down to something like 25 mgs a day. So one expects medication needs to be less high if there is other therapy going on at the same time. Especially behaviour or psychological therapy.

Q Does that have any bearing on review of this patient during the period with which we are concerned?
A It should certainly be the case that if you are getting into non-standard doses you should be asking yourself whether as the prescriber whether all that should be done in non-medication avenues is being done.

Q Does that require you to see the patient or not?
A If you are uncertain it requires you to see the patient. Though a common thing to do would be to be in touch with the local mental health team if the patient was coming from some distance away. There would not necessarily be the requirement of the prescriber to be providing that themselves. More to refer them for it.

Q Just dealing with this question of telephone review. It is apparent from the evidence that Dr Cosgrove was regularly reviewing patients by telephone and that reflected - the issue was raised in your last response - that many of these patients were obviously travelling a consider distance to see him.
A Yes.

Q I think you would not criticise that, as much, the telephone review? On the contrary?
A No, telephone interview with the parent is a good way of determining dosage need. Thought I would say that one would always recommend that there were reports obtained from the teacher as well as a report obtained from the parent because a child in school is somewhat different from the child at home. You can give suboptimal doses for school if you are titrating the dose against the way the child is behaving at home.

Q But you would say in those respects you have mentioned already there are occasions when personal face to face contact with the patient and parent is appropriate?
A Yes.
Q And necessary. I understand. May I move on to the case of Patient B. The relevant documentation in relation to of Patient B actually refers in that Committee bundle at C8, division 3. The allegations against Dr Cosgrove relate to what we allege are essentially inappropriate comments in respect of the doctor who this patient has seen. First of all I think you have indicated last week that you consider the diagnosis of ADHD to be a valid disorder in adults; that many psychiatrists do not, but that your position in respect might be closer to Dr Cosgrove’s than that of many?

A Yes, yes, that is correct. I think that probably majority of general adults that psychiatrists will be seeing that ADHD really is not an issue in adult mental health and that the problems which I would call ADHD in adult life really are those of a personality disorder or of a hypomania.

Q The evidence last week of Dr Al Shabnder in respect of this issue was that ADHD was a differential diagnosis that he had in mind but that he did not have sufficient information to come to, as it were, fixed or final diagnosis at that stage and that he wished to investigate matters further. If that is correct, would you criticise Dr Al Shabnder’s approach to having seen this patient?

A No, I would not criticise that because I think the diagnosis can be very difficult to make in adult life. Indeed, I do not think that even the experts are agreed about just what the criteria should be for recognising it in adult knife. It is not an easy judgment at all. One reason why it is difficult just relying upon what the patient is saying about his experience is that one of the things that research has suggested is that when you follow up people who have had ADHD into their adult life and compare them with the people who have not got ADHD, then you ask them in their adult life whether they did have ADHD as a child, or whether they have it now, then there is a big blur across the two, so that many people who say they have got ADHD did not in fact have it when they were children. What they are describing is something rather different. Often describing a sense, sometimes a sense of failing or worthlessness or something of the kind. It is sometimes a matter of depression and poor image of yourself rather than necessarily it being the case that the ADHD has persisted. So it is a difficult manner to make - the adult diagnosis. Even experts disagree on individual cases.

Q If then, contrary to the case that I have put, if it were the case that this Doctor had been saying to the patient effectively that he did not accept a diagnosis of ADHD as being correct, the patient was suggesting it was ADHD and the doctor was saying it was not, would you form the view that that indicated a lack of knowledge on the part of the doctor?

A No, I do not think that would be fair. Of course, it is possible that it did but there is no reason to suppose that it did. If I had seen a patient in those kind of circumstances and I thought he very definitely did have ADHD on evaluation then I would have wanted to feed that back to the original doctor as part of that doctor’s education and knowledge. But I would not have seen it as evidence of incompetence.

Q Can I then have a look at one or two other aspects of this letter and it is what Dr Cosgrove himself says about ADHD, for your comments on that. Can I take you to division 3, page 2, paragraph about a third of the way down the page, little over that begins:
“The four main characteristics of ADHD are poor concentration, impulsiveness, hyperactivity and poor motivation.”

Do you agree with that, Professor Taylor?
A I would only agree with the first three on that. The definitions of ADHD are poor concentration, impulsiveness and hyperactivity. But poor motivation is not part of the diagnosis. It can happen in it but it can happen in so many other kind of situations as well. Poor motivation is a very – it is very much a feature not only of psychiatric illnesses but of personal adversity. I think it would be wrong to be suggesting that poor motivation in itself was part of the definition of a psychiatric illness.

Q Could I ask you to look at the previous paragraph on that same page:
B “I do consider that B is very unwell with the Attention Deficit Hyperactivity Disorder which is a genetically determined insufficiency of dopamine production.”

May I ask you first of all on the to consider the comment that it is a genetically determined condition. Do you agree with that?
A No, I think that is putting it too strongly. It is a genetically influenced disorder. Inheritability estimates are high, in the region of 86. But the point is those genetic influences work in interaction with the environment. For instance, one of the genes makes you more likely to develop ADHD if you have been exposed to cigarette smoke in pregnancy. So to say it is genetically determined, the implication there is that it is – that the determination that the creation of the disorder is by the genes, which is putting it too strongly.

Q And the second part of that phrase that I have read to you, “Insufficiency of dopamine production”. Do you agree that that correctly describes the causation of the condition?
A No, I do not. I mean the evidence is quite different. The dopamine is indeed a chemical that is involved in the brain in ADHD. We do not know exactly what it is that is giving rise to the alteration of it, but the strongest view, and the clear evidence about the way the drugs act, is that what goes wrong is that there is an excessive amount of the chemical that removes dopamine from the brain; the dopamine transporter.

Q Yes?
A What the drugs are doing is increasing the levels of dopamine, not by altering dopamine production but by blocking its removal.

Q Yes?
A It is an important distinction because it relates very much to the issue of how far the drugs are like the drugs of addiction (drugs like cocaine). There is a big difference between the drugs which alter the production of dopamine and the drugs which alter its (inaudible). The drugs altering it - take it away - are much quicker than - indeed cocaine will be an example of, not the drug that blocks dopamine, a transporter.

Q Yes, I understand. Thank you. We will move on, if we may do, to Patient C and the letter that you see at pages 1 and 2 of division 4. I hope I accurately summarise what
Dr Moses said in evidence about Patient C, it was this: that she had seen the patient when he was 5, nearly 6 years old, and at that stage she had made no psychiatric diagnosis and had not thought that psychiatric treatment was necessary but the patient had been re-referred, that he had been seen by her SHO, who wanted school reports, but that the SHO had then fallen ill and had not been able to see Patient C again. Therefore, Dr Moses had, as it were, taken up the case and had seen Patient C in the August of 1998 and had formed the view that it was necessary to get reports from school. She had obtained those reports and seen Patient C again in September of 1998 and, thereafter, she had taken the view that it was appropriate that he be admitted as a day patient to Pollards Well (the Unit at St Cadoc’s Hospital) and that he had been so admitted in November 1998 and that, thereafter, at that Unit they had undertaken behavioural forms of therapy with the Patient. I think she had formed the view that the patient was not suffering from ADHD and, therefore, Ritalin and/or Risperidone were not appropriate treatments but that she had not rejected ADHD, as it were, without thinking about it; she had felt that his behaviour was, I think, somewhat variable and that that was a pointer against ADHD. That is a summary, I hope a reasonably accurate one, of what Dr Moses had to say about the treatment of Patient C.

I want to ask you, if I can, to comment on what Dr Cosgrove is saying in this letter. If that account is so, where we see on page 2 of the letter at division 4, approximately half-way down the page:

“I am surprised that more has not been done for this poor child by the local specialist”,

do you see that?
A    Yes.

Is that comment justified in your view?
A    I do not think that is reasonable, no. I think the child was still quite young. I think that it could have been a reasonable judgment, for Dr Moses to make, that he was likely to respond to the rather intensive treatment of psychological treatment, which you can get in a day-patient setting. A point comes (and if it was November when he went into the in-patient day) I would have expected that, sort of, if he was not responding after about three months after that, then, indeed, yes, the issue of medication should have been considered and reviewed actively. Hard to say without reviewing the child at that point---

---whether it was a right judgment or a wrong judgment---

---to withhold medication. In the light of subsequent events it sounds a bit like it may have been the wrong judgment because the child did, in fact, as I understand it, respond pretty well when the ADHD medication was given. But I think that trying that, trying to give the in-patient psychological work a chance to work first, would have been a very reasonable thing, a very reasonable venture.

Does the diagnosis of ADHD necessarily make a difference as to whether that is the right approach to take?
A No, not necessarily because there is quite - there is good evidence (especially in younger children) that behavioural approaches work for ADHD just as they work for other conditions like oppositional disorders, violence and conduct disorders.

Q Yes. If, in fact, six months on from having gone to the Unit the diagnosis of ADHD had been made and the prescription of Ritalin and Risperidone was made, would you say that that indicated that Dr Moses had done nothing to alleviate this Patient's malfunctioning?
A No, because plainly a lot had been done to alleviate the malfunction. I mean, the day-patient unit treatment is doing a lot; it is doing something that has got quite sound evidence that it is a procedure that is helpful.

Q I understand. I use those words because if we turn to the letter that appears in division 5 at pages 2 to 4, that is the comment that was made by Dr Cosgrove. Turning for a moment to division in the letter at pages 1 and 2 by Dr Cosgrove, that is a letter to the General Practitioner in respect of a prescription, that you see at the bottom of page 2, of Ritalin and Risperidone following the history and diagnosis made by the Doctor?
A I am sorry, I am not sure if I am in this same place.

Q I am sorry, I am moving on. Division 4, pages 1 and 2. I apologise
A Yes, I am with you now, thank you.

Q The last paragraph:

“I have made out private prescriptions for Ritalin and Risperidone but I know that his parents would very much appreciate it if you would copy them down on to an NHS scrip. On each occasion that I alter the dosage, I will send the fresh specimen prescriptions to bring to you, you may care to keep them in his file”.

It is admitted on behalf of Dr Cosgrove that this letter makes no reference to appropriate monitoring of C while he is taking these drugs that are being recommended by Dr Cosgrove. In your view should the Doctor have provided any such advice?
A Yes, I think so. I think that I part of making a shared care agreement would be indicating what was being done by who, otherwise it is ambiguous about who is monitoring which aspect of the case.

Q Just give us an example, if you could, about what Dr Cosgrove might appropriately have had to say here, assuming that this was a patient who was a little distance from---
A The kind of shared care agreement that most clinics would have would be recommending something like three monthly visit to the family doctor for the recording of height and weight on growth charts and the monitoring of blood pressure and pulse rate.

Q Yes. If I can move, please, on to Patient D. Patient D was seen by Dr Cosgrove in May of 1996. The evidence of Mrs D (Patient D's mother) is that the consultation on that occasion lasted about half an hour, that there was no physical examination of her son (the weight, height, blood pressure or anything else) and that, in
fact, there was no questioning of her son. If that is accepted as being correct, what do you have to say about the examination of Patient D on that occasion?
A I think that fell short of what was necessary because you cannot judge the effects on growth unless you know you have a baseline from which to detect any changes in the future of excess due to the Risperidone or deficiency due to the Ritalin.

Q Yes?
A Neither would you know whether there were any contraindications, such as high blood pressure and any neurological state.

Q Subsequently - or we know that Ritalin and Risperidone were prescribed, again what arrangement for monitoring would have been appropriate in this Patient’s case?
A Can I just check back where we are?

Q Please, yes?
A I want to see what medication and doses he was on to be judging about monitoring.

Q Right. You have asked me a difficult question about that?
A Sorry about that.

THE CHAIRMAN: C8 divider 6, pages 1, 2, 3. Do these help?

MR PEARCE: That is a summary of the notes, is it not, sir?

THE CHAIRMAN: I am referring to the letter from Dr Cosgrove dated 21 May 1996.

THE WITNESS: I am sorry, I do not seem to have a division 8.

THE CHAIRMAN: Division 6?

THE WITNESS: Division 6.

MR PEARCE: Division 1 appears to be the original specimen prescription in June 1996, which I think is a total of 35 mgs of Ritalin?

THE WITNESS: Yes. Thank you very much.

MR PEARCE: Page 3 of division 6 refers to, I think, an initial prescription of 10 mgs for 2 days, increasing to 20 mgs for four days, increasing to 30 mgs until the telephone appointment in about 10 days time?

Q Slightly earlier?
A Yes. Yes. So in those early stages of the treatment, one would be wanting to recommend a 6 weekly monitoring of pulse rate, blood pressure, height and weight and when the dosage is established and things are stable then to go down to the three months, that kind of figure that I was mentioning before.
Q I am sorry, I was looking as you asked - as you raised that point, Professor Taylor, I was looking at what Mrs D herself said about the Ritalin. She said in evidence that after about six months the dosage that increased to 60 mgs of Ritalin. Is that kind of monitoring appropriate to that level?

A Yes. That would be the same kind of monitoring that was sensible.

MR MORRIS: I hate to interpose, but I would just like to point out that there is no evidence that that dosage of 60 was one recommended or prescribed by Dr Cosgrove.

MR PEARCE: I am obliged for that. (To the witness) Could I ask you, please, about Patient E? In respect of this matter, which relates to the investigation by the Trust and documentation at division 7 in the bundle, I think you are familiar with this documentation, you are familiar with the complaints that Dr Cosgrove makes here. Many of them, I think, are matters which are for the Committee rather than for you as an expert to comment on. Can I ask your comments on this: towards the bottom of page 2 of the letter in division 7 Dr Cosgrove says:

“I assert that the expert will also not be knowledgeable or experienced enough with the use of Risperidone, which is not only the medication that has dramatically changed A’s treatment, but is precisely the medication that Mrs E was calling upon Dr McDonald again and again to prescribe, which he persistently refused to do so. His constant refusal to do this so was partly because of your Trust’s policy not to prescribe this medication to children”,

pausing there for a moment, did some trusts have a policy of not prescribing Risperidone to children in October 2000?

A Yes, I think that is correct. I think that some trusts still would. It is by no means universally approved. I do not think most trusts probably would have a policy at all and would leave it to the judgment of the individual doctor.

Q I understand. In your view would such a policy be criticised as being inappropriate?

A I think it could now.

Q Yes?

A Because now there is some trial evidence that - not so much for ADHD but for other indications in children, especially for aggression in children - that low dose Risperidone is an effective therapy with adverse effects that need care. The trial came out last year. Before that there was not any evidence base for prescribing the medication for children, though I still see it as a rather blanket policy to say "Never approved for children".

Q Yes.

A Because there are some indications, such as schizophrenia, in which it is very much a suitable medication for children.

Q Was there any evidence base, though, for Risperidone in conjunction with Ritalin for treating ADH?
A

Q No, and still ...
A At that time?
Q Neither then, nor now.
A Neither then nor now, I understand. Dr Cosgrove goes on to say:

B

"I am probably the most experienced specialist in the UK in the use of Risperidone with children".

Q Now I asked you to comment upon this last week, Professor Taylor, and you indicated I think that he had probably treated more people with it than anybody else?
A I think that is likely, yes.

Q Yes. And you made a comment about his expertise as well?
A Yes, I think I was saying that experience was not the same as expertise. You could do something wrong a lot and that does not mean that you have a lot of expertise, necessarily.

Q Do you consider that there are experts in this country who could have been considered as appropriate to carry out a review of the type that was being proposed by the Trust?
A Certainly, yes. Yes, as I say, the use of Risperidone in general is not unusual in young people with schizophrenia. There are plenty of people who have experience of giving Risperidone to children.

Q Yes.
A And in giving it for ADHD in particular, yes, the country would certainly have experts in that.

Q Yes. Could we move on, please, to Patient F. Now I think in the case of Patient F the relevant correspondence appears in Division 9 of the bundle; that being a letter from Dr Cosgrove to the General Practitioner dated 17 November of 2000. First of all we note reading through it that there is reference to the history, to Dr Cosgrove's diagnosis and to the fact that he has made out a prescription. We see, do we not, in the second paragraph of the second page of Division 9, which has the handwritten number "232":

F

"I have made out a private prescription for Ritalin for 5 mg om".

Q Incidentally, what does "om" mean?
A It means every morning.

Q Every morning, yes:

G

"... and 5 mg 4 p.m. for five days ..." (and so that is 10 mg a day for five days) "... followed by 5 mg qds ..." (four times a day, and so a total of 20 mg) "... for five days followed by 10 mg om; 5 mg lunchtime; 5 mg 4 p.m.; 5 mg 7:30 p.m. ..." (and so that is a total, I think, of 25 mg a day) "... until I have the first telephone
appointment with him in about two weeks after he starts the tablets. I will have a series of telephone appointments with him in order to monitor his progress and to find the optimum dosage and frequency through the day”.

And then at the end of this letter on Page 233, a paragraph similar to one we have seen before:

"I have made out a specimen prescription for Ritalin but I know that he would very much appreciate it if you would copy it down on to an NHS scrip. On each occasion that I alter the dosage, I will send him a fresh specimen prescription to bring to you. You may care to keep them in his file”.

May I, first of all, ask you about the monitoring of the dosage. If the anticipation here was that it was for the GP to carry out the monitoring, what would you say about the contents of the letter?

A Well, this is now an adult taking what for an adult is a relatively small dose of medication.

Q Yes?

A Growth is not particularly an issue in that. I think I would just point out the need for blood pressure monitoring.

Q Yes, all right. And the absence of a reference to that in the letter, what do you have to say to that?

A I am sorry, I did not catch that?

Q The absence of a reference to such monitoring in the letter?

A I think that should have been mentioned, yes, because you cannot expect the General Practitioner to have experience or to know what to do in the monitoring of treating ADHD in adults.

Q I understand. In the letter we also see criticism of Doctors Thomas and Chubb, I think, essentially for indicating that this patient had a personality disorder which was not treatable and that they demonstrated negligence in not understanding about ADHD as a real condition in adults. Well, again, the evidence from Dr Thomas is to the effect that she did not diagnose a personality disorder and that she was considering the issue of ADHD in adults, but considered that this patient should be referred to somebody who was expert in that condition. If so, was that appropriate conduct on the part of Dr Thomas?

A Yes, it is appropriate in the sense that it is a specialist consideration and, as I think I said before, the diagnosis of ADHD in adults is quite difficult. Actually finding a specialist in ADHD in adults is a much harder thing to do, I should say, and so it might be a slightly empty prescription, but nonetheless there are such people.

Q Yes. I have read somewhere, and tell me whether or not this is correct, that I think there are two units in the country, are there, that...?

A Yes, yes. There is one more, since I started with Dr Toombe, and I believe there is a clinic in Cambridge as well.
Q And that is dealing with ADHD in adults?
A In adults, yes.

Q As opposed to children where there are far more appropriate units?
A Yes, and also there is Dr Asherson who is another psychiatrist with an interest in adult ADHD.

Q On the other hand, on the basis of what Dr Cosgrove has to say in the letter about essentially what he understands about this consultation with Dr Thomas, was it appropriate in your view for Dr Cosgrove to say that Dr Thomas and Dr Chubb would be guilty of negligence if Mr F responded to treatment for ADHD?
A I do not see it as negligence. I mean it may be incorrect, but I think it would be harsh to say that somebody was negligent if they were following the policy that the vast majority of psychiatrists in the country follow.

Q And I think you have indicated that, for example, a personality disorder is something which some psychiatrists - many psychiatrists - might diagnose in a situation in which you were considering ADHD?
A Yes, they might, and in a sense it is an argument about words.

Q Yes.
A Because in that sense ADHD is a form of personality disorder in the sense that it is a long lasting disposition to react in particular ways.

Q Yes. Yes, I understand. May I move on to Patient G, please, and in Division 10 in the bundle, Pages 3 to 5 I think in particular, is the letter to the General Practitioner in respect of this patient?
A Yes.

Q And, again, I think it follows a similar format to other letters that we have seen. It makes reference on Page 4 of the letter, or of the bundle I should say, the first full paragraph second sentence:

"I have made out a specimen prescription for Ritalin for 2.5 mg 3:30 p.m. and 2.5 mg 9 p.m. ...") (and so that is 5 mg)"... for three days, followed by 2.5 mg qds ...") (10 mgs per day) "... followed by 2.5 mg om; 5 mg 3:30 p.m.; 5 mg 6:15 p.m.; 2.5 mg 9 p.m. until I have the first telephone appointment with his parents in about two weeks after he starts the tablets",

and so just doing the maths there we get up to a total of 15 mg:

"I will have a series of telephone appointments with his parents in order to monitor his progress and to find the optimum dosage and frequency through the day. They always bring him back to see me at the Clinic when required".

Now we note from the previous page that this patient was four, very nearly five, at the
date of this letter in February 2003. Can I ask you, first of all, about the prescription of Ritalin in children of this age. Is that widely accepted, or not?

A It is not. It is controversial, but there is some trial evidence for it and I would myself use medication in children down to the age of four.

Q Yes?

A Its market licence is only down to age of six.

Q Yes?

A And so one is going outside the recommendations at that point.

Q But you would not ---

A And I would tell the parents that it was outside the recommendations so that they understood that it was being done.

Q Yes.

A But, nevertheless, I think it is safe. I think after a child gets to the age of four, then I think a lot of the very early development of the brain that you do not want to interfere with with medication is done.

Q I understand. Now, sorry, just reading on in the letter, we see in the last sentence - the last paragraph, rather - on Page 5 of this letter a similar paragraph to one we have seen before:

"I have made out a specimen prescription for Ritalin and Risperidone, but I know that his parents would very much appreciate it if you would copy it down on to an NHS scrip. On each occasion that I alter the dosage, I will send them a fresh specimen prescription to bring to you. You may care to keep them in his file".

What monitoring would you expect to see in respect of this patient?

A For the physical monitoring as with older children, that is to say six-weekly checks in the first stages of the treatment and three-monthly once established, though in a younger child like this I think one ought to be pointing up the educational importance and the need to be making sure that the monitoring included informing his school, informing his teachers and making sure that they are looking carefully themselves at what the medication is doing to him. So, monitoring in the other situation as well is probably particularly important in the younger child.

Q I understand. If the contact that the parents had with Dr Cosgrove following this prescription in February 2003 up until July 2003, and so in that five month period -- if that contact was by telephone review alone without Dr Cosgrove seeing the patient, is that in your view appropriate?

A I would very much want information from another source besides the family. That might very well be the teacher, but it is important. I mean, all the guidelines stress that the idea of the medication is not to be a kind of quick fix for behaviour problems. It is not the idea just to make children easier to live with at home. And, if you do only monitor from the parental account, then you may be monitoring that in effect. You may
be monitoring the decrease in troublesome behaviour. And it is really not the point of the medication to be doing that. The point of the medication is to be enhancing the child's development and especially their development in attention and impulse control. So, you have to know something about their attention and their impulse control as well as whether they are badly behaved.

Q And what about face to face contact with a patient over that period?
A Would have been - would have been - necessary in the course of the first six months. The protocol guidelines call for it at four weeks, but practicalities mean that sometimes one would delay it until six weeks or eight weeks.

Q I understand. Just so then we get a complete picture of the level of medication, if you turn on, please, to Page 7, we have here some handwritten notes by Dr Judge who is a Consultant Child and Adolescent Psychiatrist and she records that the dosage was 5 mg five times a day on 16 May 2003, a total of 25 mgs a day there, do you see that?
A Yes.

Q And I think again on 6 June 2003 and 11 July 2003, Page 8 refers, again the dose is recorded as being 5 mg five times a day?
A Yes, yes, which is okay.

Q Yes. So, that it is clear and it does not appear that I am missing anything out, Professor Taylor, I do not think at the time you were asked to prepare a report in this case you were asked to consider the papers in respect of the final of the patients with whom we are concerned, Patient H?
A Yes.

Q You were not so asked to do, were you?
A No, I think not. No, I do not recall seeing any papers on that.

MR PEARCE: Yes. Thank you very much, Professor Taylor.

THE WITNESS: Thank you.

MR PEARCE: If you wait there, please, I think Mr Morris will have some questions for you.

THE CHAIRMAN: Do you wish to have a break just now? Would this be a logical point that we should have a break?

MR MORRIS: It might be a logical break, yes, and it will give me the opportunity to find a document that I am looking for.

THE CHAIRMAN: Well, we will have a break and we will reconvene at 5-to-11.

Could I remind you, Professor Taylor, that you remain under oath.

THE WITNESS: Yes, yes.
THE CHAIRMAN: Thank you.

(The Committee adjourned for a short time)

MR PEARCE: While the doctor is coming through I have alerted the Committee Secretary to this, when Dr Judge was giving evidence in the transcript, it is day 7, page 5, letter B, my learned friend produced some extracts from the appropriate records and they were given the exhibit number D28 which was the next in turn, I confirmed with the Secretary that indeed they were given that letter and number, in the transcript it appears apt D26, I just wanted to read in to the transcript now that there is an error there. It caused me some confusion last night. But what I called D26 on page 5 of the transcript for day 7 should read D28. I am obliged, sir.

Cross-examined by MR MORRIS

Q Professor, can I start with a few general matters. You talked about the sea change in the profession’s approach to ADHD. Is this a correct summary, that in spite of the scientific evidence that it is an effective therapy, many paediatricians and child psychiatrists were, at least until the late 1990s, strongly opposed both to use of the diagnosis of ADHD and to stimulant medication for more than very small number of cases?

A Yes. I think that is fair comment and certainly the rates of prescription have been rising substantially ever since 1995, so there is probably now something like a one third of one per cent chance of receiving the medication. So, yes, a sea change is a fair way to put it.

Q Sorry one third?

A One third of one per cent.

Q Which is still a very much lower than the figures in the US. Is that right?

A Quite right, quite right. Perhaps the figures there would be something of the order, depends where you are, something of the order of five to seven per cent. Something like 20 times as common.

Q In your opinion would that difference be explained by a difference of approach from clinicians in the two countries rather that any inherent difference between the children in those two countries?

A Yes, it would. The is opinion because the direct comparisons have not been done but in general the rates seem to be quite similar in most countries.

Q That approach, that you accept it was right, led during the 1980s and 1990s to a situation in which many families were seeking in vain for drug treatment?

A Yes, that is quite true.

Q Therapy was known to be effective and widely used internationally but was unavailable to them?

A Yes, I think many families found themselves in that situation.
Q  Does that, I do not know if you can help, does that approach from British clinicians stem from the views that were expressed in earlier times, that this condition was really limited to those children who had some brain damage, if I can put it that like that, in terms of epilepsy or other such conditions?
A  I think when you go further back, perhaps to the 1970s, rather than the 1980s, that would have been the case, yes, and I think that more recently, perhaps in the 1980s, the consideration was more that when children did have ADHD it was thought to be a fairly benign kind of immaturity, rather like the toddler stage going on a bit longer than it should and the fact that you are going to grow out of it and be perfectly okay. What changed practice was largely realising that that was not the case and it was something which had adverse consequences for later life.

Q  Professor, did your own views change during the course of those decades?
A  Not very much. Not very much. In that I think my own view in the 1970s, well, the late 1970s, early 1980s was this was an important treatment to give and not enough of it was being given. So I think my view then is quite similar to what it is now.

Q  Would you accept that certainly in the latter part of the 1990s Dr Cosgrove was one of the few specialists prepared to use the treatment at that time; that he would have encountered a good deal of media and professional hostility even though the treatment was very well founded scientifically?
A  I would that to the early 1980s and early 1990s because during the second half of the 1990s when Ritalin was reintroduced to the market then there was a considerable growth of ADHD clinics all over the country. But I think that comment about his being a pioneer in the use of treatment that would apply more to the 1980s.

Q  But as we know views changed slowly, despite published evidence. Would it be fair to say that there would be large number of clinicians still in the late 1990s who were adopting the restrictive approach not really justified by the evidence?
A  Yes, I think that is fair comment.

Q  I want to turn, please, to the specific patients. If we can start with Patient A. I want to deal with the question of monitoring of that patient. I think you made two general points in relation to monitoring, first of all there is a need for physical monitoring and, if I can call it, academic monitoring in relation to patients receiving, if I can put it like this, normal dosages up to about 60 milligrams a day where the physical monitoring could be confined to growth valuation and blood pressure and pulse readings?
A  Yes, for children on Ritalin only, yes. That is the physical monitoring. I also mentioned the need for the psychological monitoring as well, including the reports from teachers.

Q  Yes. Can we have a look then at what the position was in relation to Dr Cosgrove. Perhaps the best evidence for that is the letter he wrote, we can find that in C12, pages 71 and 72, he wrote this on 3 May to the patient’s GP, Dr Parry. He makes the diagnosis on page 71, then we go and he sets out the proposed regime in relation to Ritalin, leading up to 40 milligrams, I think, I will be corrected if I am wrong, going up to the first telephone appointment with his parents on a day which is about 10 days after he starts the tablets:
“I will have a series”,

or

“I will make”,

I am not sure,

“a series of telephone appointments with his parents in order to monitor his progress and to find the optimum dosage and frequency through the day.”

Then he goes on to talk about the product licence in relation to Ritalin:

“It is not a drug of addiction or dependence unlike the available Benzodiazepines. It does tend to cause a fall in appetite and A is already about at about 75 per cent of his pre-Ritalin level.”

Just interposing there, I think we know, do we not, that this patient had already been put on a low level dose of Ritalin by other psychiatrists?

A Yes, correct.

Q

“I will monitor his progress and have asked his mother to have him weighed so that we can see the cause of his weight.”

Is it fair to say that the important thing in monitoring growth in relation to a child being put on Ritalin is to make sure that, if I can call it the growth trajectory, remains on track and that the child does not start deviating between the centiles on the growth chart?

A Yes, exactly.

Q So in relation Dr Cosgrove’s concerns for and plans to monitor the patient’s weight, do you have any criticisms arising out of what he was proposing in that letter?

A That he should have mentioned height as well as weight because you can have changes in growth of height as well as changes in growth of weight and in some ways they are more of concern and, of course, the blood pressure and pulse rate should be in the monitoring too.

Q But no criticism in regard to weight?

A I am not sure what he is saying because, of course, it is importance not only that he is weighed but that it is plotted on the growth charts. So if what is planned is that mother is going to be away and reporting it back and he is going to be plotting it on a growth chart then that, I think, is quite reasonable at that stage of the therapy.

Q What we do know, Professor, is that weight was, in fact, monitored by Dr Holme in his regular reviews of the Patient. I think we have those if you look at pages 124, 125 onwards in C12?

A Yes.
Q     Indeed, we have the first consultation on the 13 May, 10 days after
Dr Cosgrove saw the Patient?
A     I cannot actually see that, is that on page 124, is it?

Q     125?
A     125, sorry. I have got 13 May, yes.

Q     13 May. In fact, there had been an earlier appointment fixed for the 9 May but the
Patient did not attend. The Patient, at that stage, was seen not only by Dr Holme, it
appears (the Paediatrician) but by Dr Vereker (the Consultant Psychiatrist) who had been
treating the Patient?
A     Yes.

Q     I think that we know also, from Dr Cosgrove’s letter of the 3 May, that both
Dr Holme and Dr Vereker would have had a copy of that letter by that stage because, if
we look at page 72, Dr Cosgrove has copied his letter to both those two clinicians?
A     Yes.

Q     They would, therefore, have been aware, would they not, of Dr Cosgrove’s
concern about the weight of the Patient and the requirement to monitor his progress in
relation to that? What we see there, certainly, is a note of the weight and height of the
Patient (21.5 kgs, 121cms) and we have heard from Dr Holme that the figures beside that
“2-9” are made in his hand and indicate that this Patient’s weight and height, indeed,
were between the 2nd and 9th centiles. It does not appear (I will be corrected if I am
wrong) that a blood pressure is noted specifically in that consultation, although we do see
that there was a pretty thorough examination of the heart and chest. Would that have
included blood pressure, Professor?
A     I do not think so. I think that they would have recorded what it was if they had
done it.

Q     If we just follow through quickly (and perhaps you can take it from me that
Dr Holme saw the patient then, next saw the patient on the 13 November 1996) we see
that at the bottom of page 125 the weight was 23.7, was 9th centiles, height 229 and that
monitoring went on through into 1997. 15 May on page 126, again height and weight
between 2nd and 9th centiles. Just pausing there, if I can just go back to November
1996? On that occasion blood pressure was noted 100 over 70 and growth was ticked. 15
May, as I have all ready indicated, the height and weight remaining in the 2nd to 9th
centiles. Blood pressure (at the bottom) is noted again. 13 November, the weight,
between 2nd and 9th centiles, and also height. Weight was ticked at the bottom of that
note, blood pressure noted again. And so on. In May 1998, November 1998 (going on),
the weight and height remaining between the 2nd and 9th centiles. In November the
height had gone up to between 9th and 25th centiles and the weight in the 9th. May 1999,
9th centiles etcetera. In relation to that Patient, his growth was monitored at that
frequency throughout his receipt of medication as a result of Dr Cosgrove’s prescriptions.
Is that a satisfactory monitoring of growth?
A     Yes, I would say so. Though – well I do not know whether that is being fed back
to Dr Cosgrove or not, obviously the monitoring is only satisfactory if it is being sent
back to the person who is prescribing, but if they are doing that then, yes, that is a
satisfactory monitoring of growth.

Q I accept that is an extremely fair point. I just want to check, I think that it was established when Dr Holme gave evidence - if you look, please, at the first letter back following the first consultation with Dr Holme, which Dr Vereker attended (22 May), if we look at page 93?
A Where am I, sorry?

Q Page 93 of that bundle?
A That is copied to Dr Cosgrove, yes.

Q That is copied to Dr Cosgrove. We see there that his height and weight are both between the 2nd and 9th centiles?
A Yes. I see. That is satisfactory growth monitoring.

Q Again I will be corrected if I am wrong, I think that every subsequent clinic appointment resulted in a letter which was copied back to Dr Cosgrove. Page 88, 1986 and 1987. May 1997, November 1997. We see 84 and 85 and so it continued.

Just putting into the background of this issue of growth monitoring, if I may, Professor, can I take you to the American Practice Parameters, which you talked about on the last occasion? Have you got it C11?
A Yes.

Q 95s, if I can take you to that page?
A Yes.

Q It is the second column. The subheading under which this appears is on page 92 under, “Stimulants”, I think. If we look at 95s towards the bottom of the second column, I think the final paragraph:

“Growth retardation resulting from stimulant use is a concern. Decrease in expected weight gain is actually small, although it may be statistically significant. The effect on height rarely is clinically significant. The magnitude is dose-related and appears to be greater with dextroamphetamine than with methylphenidate or pemoline. It can be minimised by using drug-free periods. Preliminary data on early adolescents show no significant deviation from expected weight and height growth velocities. Adult height has not been shown to be reduced following methylphenidate treatment in childhood”.

That was a publication issued in 1997, Professor. Has there been any new evidence that would lead one to change those commentaries that we see there?
A There has been recent evidence, yes. The analysis of – I refer to the MTA trial (the multimodal treatment assessment trial), which was a large-scale comparison of medication against non-medications therapies in America. That has produced evidence that suggests that growth retardation is more of a concern than it was thought to be before, of the order of 1 cms of height lost in a year’s treatment for the group as a whole.
Q  Just help us, please, as to when that evidence first emerged into the public domain?
A  That is very recent. That is this year.

Q  But up until that point it would be reasonable for a clinician to be guided by these sorts of comments that we see in the *Parameters* there?
A  Yes. I think I should point out that they are referring, of course, to the group there and that when they say that the decrease in expected weight gain is small, they are, of course referring to groups of children that have been studied. The whole concern is to detecting the rare problem of the child who is showing a failure to grow. The detection of a rare problem still needs to happen even though it is not a major problem or not a problem at all for those children, which is certainly the case.

Q  I am not seeking to argue for Dr Cosgrove that there is no need for monitoring of the group. It is just to set a context, if we may?
A  Yes.  It is uncommon but when it happens it is very important.

Q  You talked about dosages and upper limit for a dose being suggested by the *Practice Parameters* of 0.7 mg/kg per dose. Is that right, Professor?
A  That is correct, yes.

Q  Could we look at 95\textsuperscript{s} in the *Parameters*? The passage Mr Pearce directed our attention to, it is on the left-hand side on this publication, where the authors say:

"The usual range for methylephenadate is 0.3 to 0.7 mg/kg per dose”.

Q  There is a significant difference, is there not, between an upper limit and that phrase, “The usual range”?
A  Yes.  There is.  It is plain that they are not stating that it is impossible to give doses outside that range, but they are also making plain that 0.7 is not a recommended average; it is an upper limit of the usual range.

Q  Yes.  Is it right to say that there is, in the literature, reference to patients getting significant improvement with doses over and above that limit of 0.7, going up to as high as 1 mg/kg dose?
A  No. I cannot think of that. I cannot think of that. I am not aware of such evidence.

Q  I cannot produce the article but I can give you, I hope, a summary of it. *Sprague and Sleator* (1997), finding that although 0.53 mg/kg produced optimal enhancement of short-term memory tasks in the laboratory in ADHD children, it was 1 mg/kg which produced the maximum improvement of social behaviour in the classroom. Does that ring any bells with you?
A  Yes, indeed. That was a paper which was strongly cautioned against the use of high doses of methylephenadate because it was suggesting that you should not only titrate against classroom (?) behaviour because if you did that you landed up with a dose that is actually harmful to the child. I am not sure, off-hand, whether that is a daily dose or an individual dose that they were speaking about in that paper. Yes, I am familiar with that
A

paper.

Q It is Solanto and Wender 1989, using 0.9 mg/kg found fewer divergent responses over repeated testing on two work tasks, compared to a placebo?
A I do not think - if I am remembering that paper correctly that is not a therapeutic trial. That is a paper that was intending to examine the basic questions of single doses on cognition. I do not think that that was intended to have therapeutic implications at all.

B

Q Funk et al 1993, findings on non-verbal creativity tasks no evidence of impairment induced by Ritalin at a 1 mg/kg dose?
A I am not familiar with that paper.

C

Q Douglas, et al in 1995 using three dosage levels in their research, 0.3, 0.6 and 0.9 mg/kg per dose, and summarising their conclusions:

"The common pattern indicated linear improvements across dosages. Ritalin dosages up to 0.9 mg/kg had an increasingly positive effect on measures of mental flexibility and other cognitive processes"?

D

A Well the Douglas group would normally be reporting its doses in daily doses, rather than in individual doses, and so I would expect that to be a reference to the total amount taken in the day.

Q But I understood that the usual way of talking about dosages now was mg/kg per dose?
A There is unfortunately an ambiguity in some recommendations that you cannot always be certain whether people are talking about a single dose or a total daily dose. You understand that I am speaking from memory about these papers. I have not read them for this purpose.

Q I am sorry that I have sprung these upon you and, if you come back to us with further information, obviously you must be allowed to give it.

Now can I turn to the specific concerns and risks that you raised in relation to the higher dosages, please, and that is particularly in relation to neurological factors. I think you have mentioned perseveration of attention, depression and hallucinations. In relation to perseveration, again trying to put this into context, am I right in suggesting that the American Practice Parameters which we have before us do not make reference to that as being a side effect of Ritalin medication?

A I would need notice of that to look through the ...

Q Well the heading of "Stimulants" is on Page 92S, Professor, and a general comment in the first paragraph:

"In addition, most side effects are mild and easily reversed"?

A Yes.
"... the onset of action is rapid, the dose is easy to titrate, and positive response often can be predicted with a single dose".

Now, I do not want to delay proceedings.

A       Yes.

Q       Maybe if during a later adjournment you were to find something that would contradict that then, of course, you must be allowed to tell us about that.

A       It may be the case.

Q       Yes.

A       And, indeed, I would not regard it as a significant problem within the usual range of treatments that the guidelines are about.

Q       Right. Depression of mood - and, indeed, perseveration and hallucinations - would those be the sorts of conditions that one would expect a consultant paediatrician to pick up on monitoring a child whom that paediatrician knew was on a high dose of Ritalin?

A       Well, no, I do not think I would actually. I mean there are some paediatricians who would, and paediatricians who have made a special study of behavioural problems and of the prescription of Methylphenidate might well be expected to know about that, but I do not think that most paediatricians would at all regard themselves as capable of judging either the presence of depression or alterations of concentration becoming more restricted. I think that would be -- I do not think that would be within the competence of an ordinary paediatrician.

Q       Would a paediatrician not be able to recognise depression of mood?

A       I think not necessarily. I think that they would not regard themselves as skilled in that. Typically, paediatricians would not see that that is what they did and they would refer on to Child Mental Health Services when they suspected it in a child in their practice.

Q       In terms of more general monitoring in terms of behavioural and academic monitoring, I would like you to help us with this please. We have seen, or we can see, the letter that Dr Cosgrove wrote following three telephone consultations with the patient's mother and we see that at Pages 74, 75 and 76 of C12. You have commented, Professor, that it is important for there to be input from the school in relation to the assessment of the child, otherwise the mother or the parent might be confining his or her comments or observations to behaviour at home rather than concentration and effort at school. If we look at the first paragraph of that letter, Dr Cosgrove writes to the GP:

"I have had three telephone appointments with Mrs A regarding A. I have taken the Ritalin dosage up ... He is less hyperactive except in the evenings ... School are very pleased with his behaviour, concentration and motivation since the last dosage increase. They have noticed his self-esteem has improved".

It would seem - and it is not clear obviously beyond doubt, but it would seem - that that
information had come via the mother because those telephone conversations had been with the mother. There is no evidence that the doctor had directly telephoned the school. But it would also seem, would it not, that the reports being relayed back from the school were detailed and were not confined to considering his behaviour?

A Well, it just is very difficult to know that. I mean if indeed it is the case, and I agree it is not clear, that it was coming from the mother’s report, then all kinds of things creep in between the way that the child behaves in school and the way that parents think the child behaves at school. The reports of teachers are very often slanted towards what will encourage parents and what will encourage the child. I think that you do not really know about what is happening in school unless you do have a report from the school. I agree, yes, I mean that is ambiguous, but if it was only coming from the mother’s report about school behaviour then I think that is not sufficient. There has been some research on that which looks at the accuracy of parents’ reports about school behaviour in matching it to teacher reports about behaviour, and it looks as though parents’ reports of school behaviour are more similar to their reports of behaviour at home than to the teachers’ report of behaviour at school.

Q Well accepting that criticism, as one must, nevertheless it does appear that the school had been certainly notified of the medication that the child was on and was giving feedback to the mother ---

A Yes, that is correct.

Q --- on the effect of that.

A Yes, it does. Absolutely.

Q Whether or not that changed through the maternal prism is something we cannot say and you say there is a risk of that happening?

A Yes.

Q Over and above that in a clinical setting, if we can go to Dr Holme's clinical notes - and by way of example if I can take you to Page 127, which is the consultation on 13 November 1997 - and the related letter from Dr Holme to the GP copied to Dr Cosgrove at Page 84, where at the top of the letter in the box the problem that was being reported on was Hyperkinetic Disorder?

A Yes.

Q And then if we go back to the clinical notes there is a reference to his school, and in fact it is the first reference in the notes I believe for that consultation:

"Fisherton Manor. Holding his own so far. Self-esteem may be a little down after comparing himself with others. Doesn't seem to have best friend. Has come home three occasions with bruises",

and so there is some input there from the school but, of course, we do not know whether it is direct or via the parent.

And then he seems to have a checklist in relation to the various elements of the disorder:

"Concentration: Having to work on this area at school? How do
they handle this best at midway between tablet dosages.

Impulsivity: Varies emotional level up down ? to what extent

Restlessness: Dose dependent”.

It would appear that Dr Holme was conducting a pro forma review of the behavioural and attention aspects of the condition, would that be fair comment?

A Well, I do not see it as adequate. I mean having read that it is very uncertain.

"Impulsivity: Varies. Emotional level up and down", it is really very hard to know what is being meant by that. Potentially that is quite serious because, if what is meant is that there is a lot of emotional lability that is present - he is very up and down in his emotional moods - then this may mean, either that he should be having less medication, or that he should be having less medication. It is certainly an indication for enquiring further about what it is.

Q Right.
A So, very vague.

Q And that that is a provisional position or unresolved position is perhaps borne out by the letter from Dr Holme, if we look at Page 84, where it is said in the second paragraph:

"Mrs A is awaiting reports on how well he is doing from the point of view of concentration and impulsivity at school”?

A Yes.

Q And so a recognition that more input is required, but certainly that it is being sought and obtained?
A It is in his mind, but it is not an adequate enquiry.

Q But with further reports from the school that enquiry could be completed and made adequate?
A Yes.

Q You have talked about also in this context the combination of drugs in this case and the concerns - the sort of cardiovascular concerns - about the use of clonidine and Risperidone. Can I just deal with one matter, clonidine and the risk of hypertensive rebound I think you have talked about?

A Yes.

Q Clonidine in its licensed form is used to assist with hypertension, is that right?
A Yes, that is correct.

Q And if a hypertensive's blood pressure is reduced as a result of use of that medication and that is removed suddenly, then there can be a rebound to a hypertensive state?
A Yes.
Q If that medication is used in a child who is not suffering from hypertension, is there any risk of hypertension being caused by the stopping of clonidine?
A Well that is the concern, yes. I mean it is a concern, not an established fact. The fluctuations in blood pressure on clonidine have not been charted specifically. The reason for the recommendation about the maintenance of steady dose is from the point of view of avoidance of a hazard, rather than a hazard that has actually happened.

Q You talked about the use of Risperidone and the problems that that might cause and the fact that there was not until very recently any trial evidence in support of the use of that in the context of ADHD?
A Yes.

Q But it is right, is it not, that there had been certainly back in the late '90s open trials which were supportive of its use?
A Well, the interpretation of those trials was not necessarily supportive of its use. There are reports of its being used and there are reports of its being improved, but there was not anything like a standardised outcome scale or any evidence of overall improvement one way or the other. So, it was very impressionistic.

Q Right. But you would not criticise its use in this context. What you would say is that an enhanced level of monitoring is definitely required?
A Yes, that is correct. I am not criticising its use. I have used it myself.

Q And just finally I think on Patient A, telephone monitoring I think a good way of delivering dose so long as the dose can be properly titrated with relevant information about the child and how the child is responding to the medication both in the context at home and the school?
A Yes, that is right, and preferably some assessment at the clinic of that as well in case there are undetected problems appearing with it. There needs to be the multiple sources of evidence partly because of the kind of thing that emerged from the Sprague and Sleator study that you were mentioning, which was that you have different doses which are good for different things. That if you titrate up to the best dose for one thing, you may have the wrong dose for what you are really wanting to treat.

Q Right. Now, I wonder if we could move on to Patient B and we have got the letter from Dr Cosgrove at Tab 3. You were asked in this context about Dr Cosgrove's definition of the characteristics of ADHD at Page 2, where he said that they comprised "poor concentration, impulsiveness, hyperactivity and poor motivation".

Q You take him to task in relation to the fourth of those factors - motivation. I think you are saying that might be a factor but that it is not necessarily part of the diagnosis and can happen in many other conditions?
A Yes, yes.

Q I just want you to comment please on an extract from a publication edited by Professor Barkley called, "ADHD a Handbook for Diagnosis and Treatment". I wonder if that can be handed round? (same handed).
THE CHAIRMAN: This will be D34.

MR MORRIS: I apologise to my learned friend, I should have given him a copy earlier. I omitted to do that. Professor, just help us, please, with the editor of his publication, Professor Barkley, I think he is paced in America, is he not?

A Indeed.

Q Right at the top of the field over there. Is that a fair comment?

A Yes, he is one of the well known figures in research there.

Q In this extract from his handbook which is dated 1990 there is a passage: “ADHD as a Motivation Deficit Disorder”, which he, I do not know whether it is the editor, says:

“One of the most far-reaching and exciting developments in this decade only began to emerge in the latter half of the period. It is not likely to be fully appreciated for at least another decade or more. This was the nascent and almost heretical view that ADHD was not actually a disorder of attention at all.”

I do not particularly want to get into the technicalities of what he is saying, but he is setting out there, if we look to the next column in the final paragraph, a motivational model in relation to ADHD and talks about its appeal in relation to the condition:

“(1) its greater explanatory value in accounting for the more recent research findings on situation variability in attention in ADHD; (2) its consistency with neuroanatomical studies”,

Then regulating circuits:

“(3) its consistency with studies of the functions of dopamine pathways in regulating locomotor behaviour and incentive or operant learning; (4) its greater prescriptive power in suggesting potential treatment for the ADHD symptoms. Whether ADHD will be come to be labelled as motivational deficit is uncertain, but there is little doubt that these new theories based on construct of motivation and a more functional analysis of behaviour, are basically altering the way in which we conceptualise this disorder.”

Would it be reasonable for a clinician reading that to take the view that motivation could be one of the characteristics of ADHD?

A think that an expert clinician reading that would understand the distinction between poor motivation in the every day sense of: ‘I am motivated to do this, I want to try’, and motivation of the more technical and neuropsychological sense that is being used here. Professor Barkley is well known that for theory which has a good deal of support to it, but at the neuropsychological level the changes which happen are more like a failure of inhibition, not that you cannot concentrate. It is your failure to inhibit other things and, indeed, some of the new case studies would suggest even more strongly that it was in
a neuropsychological sense a problem in the broad area of motivation rather than of attention failure. Attention deficit is a misnomer at the neuropsychological level. That is not at all the same thing as the ordinary concept of motivation -not wanting to do things, being idle, feeling unengaged, detached. It is a difference of order of talking about things. Yes, I can well see that an unprepared clinician might be confused but I am not sure that would not be the intention of Professor Barkley who has been one of the great advocates in setting out the diagnostic criteria for ADHD of ensuring that the main behavioural things that you go for are, indeed, inattentiveness, impulsiveness and overactivity. He has not suggested, indeed he has argued against adding qualities of motivation in that more general, broadly based sense of the definition.

Q So you still criticise Dr Cosgrove for including poor motivation as one of the characteristics?
A I criticise it because it can lead to an over inclusiveness, which is if you were to include being poorly motivated to do things in the definition then that could well lead you to include more people in the diagnosis that should be diagnosed. You have included a non-specific bit in the definition rather than the things which distinguish it from other kinds of problems.

Q I want to move on to Patient C, if I may, you will find that at divider 4 and 5 in the bundle. Criticism here in relation to the letter of 29 May 1999 in the heads of charge that there was a failure in the letter, the fact of the matter is the letter does not contain any advice to the GP about appropriate monitoring of C whilst he was taking Risperidone and Ritalin. Help us with this scenario though, please, if in fact Dr Cosgrove himself and Dr Rackham, the GP, were between them monitoring growth and blood pressure would that be an appropriate monitoring regime in the context of that patient?
A Yes, I would think so. This is a child on ordinary dosage. He is on Ritalin and Risperidone. So there is – he is on quite a lot of Risperidone, so there would be an issue about ECG there, I think. I think a cardiogram would be proper. But from the point of view of the growth and the blood pressure, yes, if the GP is monitoring these things and feeding that back to Dr Cosgrove, the prescriber, then that is an okay way of doing that. Though, as I say, the combination with Risperidone creates some other issues.

Q Can I just ask you for your views on this, we see here clearly a critique of Dr Moses which is based on what Dr Cosgrove was being told by the patient’s mother. If we look over the page at page 2:

“Mrs C told me that C was seen by Dr Moses…when he was five years old but she was given no diagnosis. At this time she was being called into school every week and she considers that her son was hyperactive at that age. Dr Moses C saw C again when he was six, had a half-an-hour talk with his mother and told her that she would see C again in one year’s time. His mother says that Dr Moses had seen C three times in four years. In view of the serious state that C is now in I am surprised that more has not been done for this child by the local specialist.”

Can I ask you pose to you a different scenario from the one that was put to you by Mr Pearce, if that account given by the mother was correct would you criticise Dr Cosgrove for expressing surprise that more had not been done?
It hinges really on something which I do not know, which is how much time had elapsed between the start of the rather intensive psychological treatment and the point at which this is being done because it is reasonable, as in the various guidelines, to begin with a course of psychological therapy and, of course, that does not have to be given by the individual consultant psychiatrist and it usually is not. In this instance what was done was more than would usually be done because of the child was taken to a day unit, which I presume would be for purposes of increasing behavioural training, of enhancing his sense of security, of working with parents, all things which are good and most children do not get that sort of level of input. Most children get that kind of thing done with a relatively small number of out-patient appointments. So to get into a day patient unit is quite an intensive thing to be provided by the local child mental health service. There is a question, I am not certain about the answer, about whether that local service went on for too long, trying to help things that way before they had gone on to medication or not. I am not sure about the answer on that but I do not see it as negligence by trying to do it by psychological input first.

Again the facts are not resolved. It is a matter for the Committee to resolve them, if they see fit. If the position was that there had been a fairly lengthy period of intensive psychological treatment and there were still remaining marked problems of adjustment, to such a degree that social service help was being sought for support of the family and special education recommendations were being made, it would be proper at that point to actively consider the possibility of medication and treatment, would it not?

Yes, it would, yes.

The history here, which we have set out earlier on in the letter, of early onset, highly persistent pattern of poor behaviour, poor academic progress in school, mother’s account that he is very restless and, I think, from the clinical notes, nurse’s reports and observations that he was chaotic in his play and unable to control his temper, it would all point in the direction of ADHD, would it not?

Yes, I thought so, yes, though I also thought there were pointers to other things happening. Also pointers to insecurity in his home life which could also be contributing to that situation. This is an issue that I have seen over the years as well as when services can sometimes be a bit slow to see what can be done in therapy. But what you need to do then, I think, is to try to get again a sort of a shared care approach with the local service because the need for psychological input does not disappear because medication is being given. Most children, perhaps not all, but most children on medication do need psychological input too. So if you are not providing that yourself you need to the work with a service locally that is giving it.

It is presumably difficult to work with that service if that service is not prepared to accept a possible diagnosis of ADHD?

Yes.

And the need for medication?

That can be a problem. Though in my experience I think that has always been resolved by discussion and professional approach and by making it plain that if medication is given it is in the spirit of a trial and if it is not helping it is not continued. So I do not think I can think of any instances where a service locally has been totally obdurate in that matter.
Q Patient D, please. I have the documentation at divider 6. The consultation with Dr Cosgrove was on 21 May of 1996, we have that at page 2, and it is right that the letter does not make specific reference to growth and the need to monitor growth in the letter to Dr Taylor but what we do have, Professor, I wonder if you can help us with this, is that on the 4 June, which is a few days later, after the Ritalin had been going for a few days, I think it was started on 24 May. And a note from the General Practitioner, we can see it at D30, I do not know if you have bundle D30 there before you?

A D30? Just a minute.

Q Page 213. I think we know from the mother that the General Practitioner Dr Taylor was initially reluctant to prescribe the Ritalin but then contacted a consultant, a lead paediatrician on it, and it was agreed after that consultation that Ritalin could be prescribed and the General Practitioner agreed to do so. We have got a monitoring regime set out there: height and weight three monthly, it looks like it is to be done by the practice nurse. In the context of a patient who was being recommended a dosage of Ritalin going up to 35 milligrams a day, that would not be an unreasonable regime, would it?

A Looks like – yes, it is fine. Looks as if (looking at things before it) this is when Dr Barton is about, is that right?

Q Yes, that is right?

A Yes. Dr Barton is a quite a well-known specialist in the area. Yes.

Q We know that Risperidone was then added into the equation on the 17 July. We have got a doctor's letter, we can see that at C8 divider 6 Page 5, 6, and 7?

A C8 divider 6? I do not seem to have a divider 8.

Q It is the main bundle that I think you were looking at, which we have been going through with other patients?

A Yes, I have got C6. I have got C7. I have got C9. Sorry.

MR PEARCE: There is a confusion between tabs and exhibit---

THE WITNESS: I have not got a tab 8.

MR MORRIS: It is tab 6. Sorry, did I say tab 8?


MR MORRIS: Page 5. Not very clear?

A Page 5, yes.

Q He writes this:

“Since I wrote to you last, I have had three telephone appointments with Mrs D regarding D. I have taken the Ritalin dosage up from 5 mg (to 35 mg is the total). Initially D's aggression ceased on a 10 mg dose and his mother was very pleased with 30 mg per day on

D9/33
this dose his teacher could not believe the change in him. At home his mother is finding him getting angry with tablets wore off”.

There is a description of his aggression.

“Clearly he needs the Ritalin but I cannot increase the dosage at present because his appetite has fallen considerably and he is awake until after midnight. I have, therefore, decided to add low dose Risperidone to the Ritalin and have asked his mother to give him”,

dosages set out there increasing, I think, to 2 mg a day at the end of that programme.

“Until I have a telephone appointment with her about in 10 days after he starts the Risperidone”.

I do not think you would criticise him for introducing Risperidone in those circumstances?

A No, not necessarily. I mean I do not know all the circumstances but it is a treatment to be cautious about as it is a sort of a last resort kind of treatment in this context. He was going into it quite early. The usual recommendation would be that if you felt you had a sub-optimal response to one stimulant that you then try another stimulant. If that was not helpful then you would then try one of the other second line of medications, which at that time would probably have been an anti-depressant such as Inipromine. So the protocols suggest that you do not go to Risperidone as quickly as that because of the potential adverse effects. He is going to it quickly, but I do not – I think while it is not in keeping with the protocols and the usual guidance, I do not think it is necessarily wrong. It may have been right for the particular child.

Q It may have been something to do with the fact that he felt that he was coming up against a ceiling in relation to stimulant medication because of the concerns about appetite and sleeplessness?

A Yes, exactly. As I say the usual thing at that point would be to try a different stimulant and then another less - a second line drug.

Q The monitoring regime that had been set up in Scotland for the child, would that be satisfactory in relation to the addition of Risperidone?

A No. I think you would need more than that. You need more frequently pulse and blood pressure monitoring when you are starting the Risperidone because you get blood pressure drops in the early stages of therapy. As I say, I really think they should do a cardiogram as well if they are prescribing both drugs at that level because if Risperidone were to create an intra-cardiac conduction problem and if the Ritalin were to increase the heart rate then the combination of the two could be awful. In fact, that could be an arrhythmia starting. Improbable, but possible.

He says it is low dosage Risperidone. It is not really very low dose Risperidone. That is a similar kind of regime that you will be giving in treating schizophrenia in a young person.

Q I do not think I need trouble you with Patient E. If we move on to Patient F? The letter in relation to this patient is at divider 10. If I can put this scenario to you,
A

Professor: if the clinician who had previously been involved in that case with the patient, who is an adult patient, had made the comment that a concentration problem (in other words ADHD) as a diagnosis, “Is for messy kids”, in other words it is not appropriate for an adult, would it be fair to describe that as a comment born out of ignorance?

A Yes. It sounds like an unacceptable comment, whatever it was made out. It sounds quite unprofessional.

B

Q If it were right that the patient had been told that the consultant thinks you have got a personality disorder, “Which is not treatable”, again it would be fair and proper to criticise that remark, would it not?

A Not necessarily the personality disorder remark because in many ways adult ADHD is a kind of personality disorder; it is a persistent problem, it not always comes and goes, it is a persisting impact upon the personality of function.

Q But if that is treatable?

A That and many other kinds of personality disorders are treatable too. So the implication, if it is a personality disorder it is not treatable, that would not be the general view.

Q That would be an inappropriate comment, would it not? “You have got a personality disorder and it is not treatable”?

A I would have thought that would be – even if it he had been right and it was not ADHD, then to say, “You have got a personality disorder and it is untreatable”, is not what psychiatrist would usually say.

Q Can I just go back, please – sorry, I am going out of order - to Patient A? I think that you said that in your own experience, I think, your maximum prescription of Ritalin was 85 mgs a day?

A I think I said that some while back. I have been up to high doses since, especially with adult patients, of course.

Q Right. I just want you to help us (it is a document that the Committee does not have), it was in the material disclosed to me earlier today and it relates to the referral of this patient to you for a second opinion?

A Yes. Yes, indeed.

Q I am looking at the recommendation in relation to medication, which is actually signed by your SHO but I will be interested to find to what extent you had input into this:

G “Management in relation to medication. Switch to a immediate release Ritalin is recommended to maximum recommended dosage of 0.7 mg/kg per day, i.e. 30 mgs TDF”,

which would be 90 mgs a day?

A Yes. I think that is correct. I should say---

Q Can you reconcile that with your 85 mgs---

A Yes.
Q --maximum---
A Well, I think that when I said it, that is was true at the time. My dosage rate has, if anything, been increasing as I have appreciated the big range that people have. I think that that 90 mgs was the highest that I have ever recommended. It came for a particularly problematic child, who had been very much round the houses and was not responding in the expected way. But that was my recommendation, yes, not the SHO’s. I do not have that in front of me and I have not seen that for a year or more because it was faxed up yesterday when I was not at the hospital, but from recollection that would be correct.

Q Right I do not want to take undue advantage of you but did you see the patient yourself or was it your SHO?
A No. I saw the patient myself.

Q Did you take a medication history?
A No. The SHO would take the medication history and tell me about it.

Q Just one last point, if I can ask you, Professor: did you write something in the British Journal of Psychiatry, earlier this year saying that you yourself had received threats from an anti-psychiatry organisation?
A Yes, I did.

Q What was the organisation’s threat threatening you?
A It was the Church of Scientology.

Q What was the nature of the threats that they issued?
A This is a little while back, but it was that I could escape the revenge that was going to be put upon me - I have not got the words exactly - but I could escape the revenge and live a natural life if I renounced my crazy views.

MR MORRIS: Yes. Thank you.

THE WITNESS: It is a few years ago, but it is still rankles.

Re-examined by MR PEARCE

Q Yes. Could I just return to that literature to which you are referred, in the sense of you have been asked about it, Professor Taylor, just so that I correctly understand what you are saying about it? I think that we hear, with the exception of the paper suggested, I think by Funk et al, not the paper that was actually produced, there were four references to literature about the levels of prescription?
A Yes.

Q I think of the four references you were aware to a greater or lesser extent of three of them, but the fourth you said you had not heard of?
A I could not recall it at the time.

Q You could not recall?
A Yes.
Q Excluding the one you cannot recalled, therefore, no doubt you cannot comment on it, in your understanding do any of the three other items of literature referred to support a higher therapeutic dosage than the levels of which you have been speaking? 0.7 mg/kg?

A No, they do not. That is to say either they are specifically arguing against it (in the case of Sprague and Sleator arguing that the higher doses do adverse things to your cognition, your understanding) or that the trials are not therapeutic trials, they are things that are designed in the laboratory to show what the drug is doing, rather than to be saying what the practice ought to be.

Q And forgive me if I am asking a stupid question but, just so that I am clear, why can one not carry over from trials in the laboratory to therapy at the kind of levels that may be talked about in the laboratory trials?

A Yes, I think the key reason for it is that ADHD is a complex problem. It is not one deficit. It is several different problems. In a laboratory experiment you will be wanting to find out what the dose response is between medication and one of those components. It may for instance be the ability to switch your attention selectively from one thing to another, which would typically need a low dose to deal with it and would be worsened at a high dose, or it might be a laboratory test such as preferring to wait and hold yourself back - the more motivational aspect of refraining from jumping in to do things in the first place - which would require a higher dose. So, I think it is quite proper for experimenters to be looking at the effect of those dose response upon different bits of neuropsychological function.

Q Yes.

A But of course in the real world we are not treating neuropsychological function, we are treating children, and what we want to have an impact upon is about their ability to develop normally. So, it is a much more overall judgment that you need to make about response in a trial.

Q I understand. I understand. Could I ask you specifically about two matters relating to Patient A, Professor, and I think for this purpose I need to turn up the Exhibit C12. My first question is about weight monitoring. You were referred to Pages 71 and 72 in D12?

A Yes.

Q You will recall that this was the early letter of 3rd May 1996 from Dr Cosgrove to the General Practitioner in which reference is made on Page 72, the second page of the letter, to a fall in appetite and the need to monitor progress and weight?

A Yes.

Q Further down on the same page the third full paragraph on that page begins thus, does it not:

"I understand from Mrs A that Dr Vereker is concerned about his weight which although it has not dropped has not increased either. However, I have been told that his weight is on the 50th centile and this does give us a lot of leeway in raising the dose of Ritalin".
Bearing those two sentences in mind, can I just ask you now to turn over to Page 125 in that bundle which is Dr Holme's note following a clinic on 9 May 1996 - I am sorry, 13 May 1996 - and so it is a clinic ten days later, where the weight is recorded at 21.5 kgs and Dr Holme tells us that he marked that as being the 2nd to the 9th centile?
A       Yes, indeed.

Q       Do you see that on Page 125?
A       Yes, indeed. Yes.

Q       Now if the Committee reaches the conclusion that in the consultation with Dr Cosgrove he did not measure this patient's weight but took this patient's weight from what he was told, what would you have to say about that as to his clinical treatment?
A       Well, I think that would just be wrong. You have to measure the child yourself. If he has just taken the weight as told to him by another, then that really would not give him anything like the information he needs to be monitoring the effect of the medication and especially with a concern about his appetite.

Q       I see. Now, in the same bundle could I ask you to look at Page 68?
A       Yes.

Q       You were asked about monitoring of blood pressure and pulse, I think, and you will see that on 3 July 1999, this is a letter from Dr Cosgrove to Dr Holme and I think it is apparent from this letter that Dr Cosgrove has seen this patient with face to face contact on 30 June 1999, the second paragraph indicates that Dr Cosgrove took the blood pressure and took the pulse rate on four separate occasions concern having obviously been raised about a tachycardia by Dr Holme. Do you see the third paragraph:

"I asked his mother to try taking his pulse and it would appear that she does not find this too easy so that her previous readings of 60 and always less than 100 are unreliable".

If Dr Cosgrove was relying upon this patient's mother to take the pulse, would that in your opinion -- and presumably to communicate it to him. I think it is implicit in that paragraph that figures have been passed on to Dr Cosgrove. Would that represent adequate monitoring of pulse?
A       No, I do not think that would be adequate, and it would be unnecessary because it can be done through the local family doctor.

MR PEARCE: Yes, I follow that.

THE CHAIRMAN: Thank you very much. It is now open to the Panel if they have any questions. The Panel has no further questions and so that I assume concludes your evidence, Professor Taylor.

THE WITNESS: Thank you very much.
THE CHAIRMAN: Thank you very much for coming to assist us.

MR PEARCE: Thank you, sir. Thank you, Professor.

(The witness withdrew)

MR PEARCE: Sir, that concludes the case for the GMC.

THE CHAIRMAN: Thank you very much.

Mr Morris, I am not sure if the case for the Defence has actually concluded?

MR MORRIS: Sir, I do not wish to conclude the case for the Defence. I just want to confirm one matter, which I would need to do, as to what course I now propose to take. I wonder if the Committee might consider taking an early adjournment and resuming an hour hence?

THE CHAIRMAN: And when would you wish or when do you think we should be resuming?

MR MORRIS: Well, the matter I wish to investigate will take a very short while. I could then come back and be less elliptical with the Committee and perhaps the Committee would prefer that before having a luncheon adjournment?

THE CHAIRMAN: Yes. Well, what I could suggest is that we could break for lunch just now and the Committee will be available to recommence at 1:45 or at whatever time thereafter you find appropriate.

MR MORRIS: Well I am content with 1:45, yes.

THE CHAIRMAN: Are you happy with that, Mr Pearce?

MR PEARCE: Yes, although - and I may or may not be anticipating what it is that is going through my learned friend's mind - it might be that to take ten minutes now to examine it might give us a clearer view of the course. I think my learned friend was rather hinting at that and then pulled back from saying it, but I think that that is what his thinking is, if I anticipate it rightly, and I notice him nod. Frankly it might assist us all, and it might assist me in terms of what I need to be working on in the next hour or so, if we were a little clearer as to where the case is going. You will follow that, if it is the end of my learned friend's case, then the next stage is me making my closing submissions.

THE CHAIRMAN: Closing submissions, yes.

MR PEARCE: And not that I am not very keen and willing to do so, but it does make a difference as to how I spend my next hour or so.

THE CHAIRMAN: Right. Well, what we will do is we will break just now and you can call us back in when you have got more information. Clearly if no more evidence is being led we are into the closing submissions.
MR PEARCE: Absolutely, sir.

THE CHAIRMAN: Whereas if further evidence is being led then that is a different ball game altogether.

MR PEARCE: I understand, sir.

THE CHAIRMAN: So, we will adjourn just now.

MR MORRIS: I am very grateful.

(The Committee adjourned for a short time)

THE CHAIRMAN: Mr Morris?

MR MORRIS: Sir, I am grateful for that short adjournment.

I am going to make application under Rule 50 (1) of the Rules that the Committee receive before them the Witness Statement or Proof of Evidence that was made by Dr Cosgrove in relation to these matters dated - I am sorry, just give me a moment please - 23rd October 2002.

Now I have alerted my learned friend that I propose to make that application, Dr Cosgrove not being here to give evidence himself, and he understandably before hearing me make that application and responding to it would wish to have sight of the document which I seek to put before the Committee and to take instructions as to the approach that the Council are going to adopt to the application and that is what I will do now. But given those factors, sir, what I would invite the Committee to do is to adjourn now and allow my learned friend to absorb the document and take instructions and, once that has been done, I can make the application fully and then Mr Pearce can respond to it.

THE CHAIRMAN: Mr Pearce?

MR PEARCE: Yes, sir. I was aware that the application might be made and I was aware that my learned friend was being elliptical. I have not been shown a copy of the statement thus far, for which I do not criticise my learned friend for a moment. I understand why that is. I am told it is a very lengthy document. Replying to the principle of whether it ought to be admitted under Regulation 50 may not require a careful consideration of every paragraph in the document, it may be matters of more general application than that, but you will understand that I do seek both to read the document and - a matter which may be at least as time consuming as that - take instructions on the document before I respond to my learned friend's application.

What I would invite you to do is to adjourn now until 2 o'clock, which will give us just a little bit over an hour, and I will give you a progress report if I am not ready then. Now given where we are in timescale terms I am obviously particularly concerned that we should make rapid progress with this, and I know you will be concerned with it as well because no doubt the application will take some little consideration by the Committee,
and so I would like to think that I was as ready as soon as possible to 2 o'clock.

THE LEGAL ASSESSOR: If it assists both Counsel the advice that I would give to the Committee, at least on what I have been told so far, is the same advice that I gave to the Committee when it was your application to admit Dr Chubb's and Dr Dover's evidence.

MR PEARCE: That is helpful, if I may say so.

THE CHAIRMAN: Well, since it is under the same rule it would only be logical if the advice were the same.

So, we will accede to your request and we will be available at 2 o'clock, or as soon as possible thereafter.

MR PEARCE: I am obliged, sir.

THE CHAIRMAN: Thank you.

(The Committee adjourned for lunch)

MR MORRIS: Sir, I am grateful for the time you have allowed both myself and Mr Pearce. As I indicated before the adjournment I make application under Rule 50 for Dr Cosgrove’s witness statement to be admitted into evidence before you. Can I say at the outset that I do not seek to make any submission that the statement is admissible under the provisions of sections 23 and 25 of the Criminal Justice Act 1988 because I do not have instructions as to the current whereabouts of the Doctor and, therefore, I am unable to submit, for example, that he is not available by reason of his absence overseas.

So I go immediately to Rule 50, which states this:

“(1) The Professional Conduct Committee may receive oral, documentary or other evidence of any fact or matter which appears to them relevant to the inquiry into the case before them:

Provided that, where any fact or matter is tendered as evidence which would not be admissible if the proceedings were criminal proceedings in England, the Committee shall not receive it unless, after consultation with the Legal Assessor, they are satisfied that their duty of making due inquiry into the case before them makes its reception desirable.”

The first issue, therefore, in my submission, you have to consider is whether or not this is, or may contain matter which is apparently relevant to the inquiry into the case before you. This is a witness statement that was formulated by the Doctor in relation to the allegations that were forwarded to him by a Rule 6 letter and in preparation of a response to be put before the Preliminary Proceedings Committee. It deals with some, but not all of the current heads of charge, so it does not deal with head of charge 11, that is Patient H or Patient G. It does not deal with the last two patients but does deal with patients A to F. In my submission, there can be little dispute but that the material within the document is
or would appear to be relevant to the inquiry into the case before you in as much as it sets out the Doctor’s case in relation to the allegations made against him.

The next consideration then you have to make is whether or not to overrule the proviso that such evidence shall not be perceived if it is inadmissible in criminal proceedings unless, after consultation with the Legal Assessor, you are satisfied that your duty of making due inquiry into the case before them makes its reception desirable.

In my submission, it is clearly desirable that this document be received into evidence before you. It is relevant to the issues that you have to decide and in satisfying yourself that it is part of your duty to make due inquiry into the case, in my submission, you have to ensure that in making inquiry into the case the inquiry is conducted fairly and it would, in my submission, not be, it would deprive Dr Cosgrove of a fair hearing in this case if his witness statement were not before you at all.

Obviously the weight to be attached to that witness statement is a matter which you will have to consider carefully and clearly you will not accord as much weight to it as you would had the Doctor given evidence in accordance with that statement and been available for cross-examination by Mr Pearce and to questions from your Committee. But that is, in my respectful submission, another issue which does not effect the question of admissibility and desirability of having that document before you.

So if I can put it in a nutshell, you cannot, in my submission, make fair inquiry into this case without having that document before you. It behoves you to consult with the learned Legal Assessor in deciding whether or not part of your duty of making due inquiry is to have that document before you and if I can take you - we are grateful for the learned Legal Assessor's suggestion that his advice would be similar to the advice that he gave in relation to Mr Pearce's application to admit the witness statements of Dr Dover and Dr Chubb – to day seven, page 42C your learned Legal Assessor said this:

“If you reach the point that the evidence is inadmissible as per the rules of evidence”,

that is a reference to the Criminal Justice Act,

“which I have described to you, you then have to consider, if you are going to make a due inquiry into this case, is the reception of that evidence desirable. That is very close to the question of whether or not the evidence is in itself relevant to the charges.”

I just interpose there. In my submission, there can be very little doubt as to the relevance of the charges in this document.

“It will hen be a question of fact whether or not you consider that evidence, as such, that it crosses the line from being relevant to being desirable, its reception being desirable. I do not think I can elaborate on the words desirable and relevant, they are English words used and it is a question of fact for you to decide that.”
The desirability, in my submission, arises out of the need to accord the Doctor a fair trial in relation to these allegations.

Those are my submissions.

MR PEARCE: Sir, our position is that we are neutral on this application. We do not oppose it, nor do we accept that the statement ought to be admitted. We invite you to hear my learned friend’s application. We can assist in these ways, I hope. First of all, I have had an opportunity to look at the statement and there can be no question but that it contains very little information on the charges before you. We thoroughly, wholly accept that it contains relevant material. Secondly, when you are considering the issue of desirability the absence and the reasons for the absence of the witness are matters which, in our submission, you can take into account and that is for this reason, that if you admit a statement such that is, just as the statement you admitted last week, the same point arises, where the author is not available for cross-examination it might, in certain circumstances, be considered undesirable that the evidence go in without the opportunity of cross-examination. The reasons why the doctor is absence are at least potentially relevant to that. Unlike the position last week my learned friend is not in a position where he can give the Committee any good reason for the absence of the doctor. As in all cases where the statement is admitted without the author being called you do not have the opportunity to hear the evidence tested. It may very well be right that goes at least to the issue of the weight you attach to the document, as it does to whether you should admit it, but the point is there to be made.

May I also make the point, sir, that this witness statement has exhibits to it that include documents from Patient B, Mrs C and Mrs E. I have made inquiry about this, in each case they are signed documents. In the cases of Mrs C and Mrs E you have heard from them in any event. I do not think you will find there is any radically different information there. By admitting the statement you would, through the fact that it contains an exhibit, also be admitting information from Mr B, admittedly in the form of a signed document from him, and it may very well be that if you were separately asked to consider the reception of that statement you would consider it desirable to do so. I simply draw that out, one has not only the statement itself, but other information within the statement comes from other sources. We invite you to consider whether to exercise your powers, but we are neutral (Inaudible).

THE CHAIRMAN: Mr Morris, do you want to come back in on the nature of the exhibits that are attached to the document?

MR MORRIS: Sir, no I do not. In my submission, they are relevant to the issues concerned. If it is felt separate application ought to be made in relation to the statement by Mr B I do so make that application for the same reasons that I make in relation to the witness statement itself.

Sir, all I would say otherwise in response to my learned friend is that the absence of good reason for the Doctor not being here goes, in my submission, much more to the issue of weight than the issue of admissibility itself; particularly where the statement in this case is from the defendant, the subject of the allegation, who is on trial as opposed to prosecution witnesses.
MR PEARCE: May I just make one concession, so it is clear. I agree that as well as the statement being relevant, the statement of Mr B that I referred to is also relevant and no separate consideration arises in relation to that.

THE LEGAL ASSESSOR: Can I ask both counsel if they know of any authority that bears on the interpretation of the meaning of the word desirable? I do not know---

MR PEARCE: I know of none.

MR MORRIS: No.

THE LEGAL ASSESSOR: All I can do is repeat the advice I gave in relation to Dr Chubb and Dr Dover. It is a matter for the Committee to decide whether they are satisfied that their duty of making due inquiry into the case before them makes the reception of the document desirable. What I would say is this, if you come to the conclusion that it is desirable, and there does not seem to be any doubt that this is relevant evidence which is being sought to be adduced, I would be advising the Committee when I come to give the advice before going into camera that the weight which can be attached to Dr Cosgrove’s evidence and to the evidence of Dr Dover and Dr Chubb, the weight that can be attached to that evidence is lessened by the fact that none of those witnesses have been subject to cross-examination. So I think you have to consult with the regards the desirability of admitting this evidence. I would say it is a matter for you to decide, but one way in which the matter could be dealt with is to receive the statement in evidence and then to take into account the fact that there is an absence of cross-examination in assessing its weight.

THE CHAIRMAN: You are looking a little quizzical, Mr Pearce.

MR PEARCE: I am not meaning to, sir.

MR MORRIS: No, thank you.

THE CHAIRMAN: At this point we go into camera.

STRANGERS THEN, BY DIRECTION FROM THE CHAIR, WITHDREW AND THE COMMITTEE DELIBERATED IN CAMERA

STRANGERS HAVING BEEN READMITTED

THE CHAIRMAN: Mr Morris, the Committee has considered your application and has decided that the witness statement should be allowed.

MR MORRIS: Sir, I am grateful for that. I hope that the Committee will forgive me for not anticipating the outcome of your deliberations, we have not had it copied yet (it is a bulky document) and we will do that now so that each Committee member can have a copy of it.

Just logistically, as to how we proceed now, it is, as I have indicated, a bulky document
and I think that it probably comprises of about 200 pages. My learned friend, as you understand, has only had sight of it for a couple of hours and, therefore, I would anticipate that before he begins submissions - I am sorry, this piece of evidence is the sole piece of evidence that you are going to receive in the case of the Doctor at this stage. It, having been received into evidence, will be the case for the Doctor. It will take the Committee some time, I think, to read that document and no doubt you will consider that you do need to read it before my learned friend starts his submissions. I think that my learned friend will require further time, in turn, to formulate his submissions, having had the chance to absorb the material.

I would, therefore, propose - perhaps the most satisfactory timetabling arrangement would be if the document went into the evidence now and the Committee had the opportunity to read it and if submissions on the evidence were to begin first thing tomorrow morning.

I have discussed that with my learned friend and I take the view that this case could comfortably conclude by a reasonable hour on Friday, if that course of action were taken.

THE CHAIRMAN: Is it your intention that the document be read into the transcript in the same way as the earlier documents that were submitted in this way? Or is it the submission that the Committee would adjourn now and read the document and accept the evidence within that document already expressed and that we start with closing submissions? Or do you want to make further submissions on the document tomorrow morning?

MR MORRIS: No, I do not. I would be content if it were taken as read rather than have it read into the transcript, which would be extremely lengthy and, I think, perhaps not an altogether helpful procedure.

THE CHAIRMAN: So be it. We will accept the document now. We could adjourn the hearing and reconvene at 9.30 tomorrow and we will have closing submissions at that stage.

MR PEARCE: Yes.

MR MORRIS: Yes.

THE CHAIRMAN: Thank you very much.

(The Committee adjourned until 9.30 the following day)
MR D MORRIS, of Counsel, instructed by Messrs RadcliffesLeBrasseur, appeared on behalf of Dr Cosgrove, who was not present.

MR R PEARCE, of Counsel, instructed by Messrs Field Fisher Waterhouse, appeared on behalf of the Council.
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THE CHAIRMAN: Good morning. I will just confirm that the Panel has received this witness statement, the response to the initial communication from the GMC, and we will label the bundle D35.

MR MORRIS: Sir, that evidence having been admitted, I call and submit no further evidence. That is the case for the doctor.

THE CHAIRMAN: Thank you very much.

MR PEARCE: Sir, may I start off by making certain general comments on the evidence before this Committee, turning to the individual charges and then to other general matters relating to the judgement that you are making at this point in the proceedings.

In my introduction to general matters, may I start from Dr Cosgrove’s statement? You may think, sir, that that statement contains much invective directed at a number of people, some of those named in charges, other people from who we have heard during the course of this hearing, others of whom we have heard mention, still others who have played little, if any, part in the proceedings. I urge you from the beginning, sir, not to be swayed against Dr Cosgrove if you consider that that statement does contain invective, regardless of whether it can be justified; not to be swayed against him into thinking that because he has criticised others in that document that those heads of charge with which we are concerned here are therein made out.

The tone of that statement is, you may think, of little assistance to you in dealing with matters at this stage of the proceedings, save in one respect, and that respect is this. When you are considering criticisms that we make of Dr Cosgrove for acting in an unprofessional, an unjustifiable or an unsustainable manner in criticising others, when you are considering that assessment and whether that is made out, it may be that at times the tone of Dr Cosgrove’s statement assists you in making that judgement.

Equally, as we have invited you not to hold against Dr Cosgrove any invective that you may find in his statement, we invite you not to hold against Dr Cosgrove the fact that you have not heard from him in evidence. He is not obliged to be here, he is not obliged to give evidence in respect of these charges. In our submission, his failure to do so should not be held against him at this stage of the proceedings in any way, shape or form, save for one – and this is not so much holding it against him as how you assess the evidence. Again, when you come to make judgements about whether comments that have been made are justified, are sustainable, are professional, if you find that, as it were, on the face of the documentation these comments cannot, you might think, be justified and sustained, then his failure to give evidence before this Committee to give those explanations as it were deprives you of one limb of evidence that might have assisted him. But that is not holding against him, that is simply assessing the evidence before you and having regard to the fact that though you have a statement he has not been cross-examined on it, you have not been able to test the weight of what he has to say insofar as he seems to justify the relevant charges.

Turning to those comments on Dr Cosgrove’s statement, I shall again, whilst remaining at the level of the general rather than the particular, to make certain other comments on the evidence that you have heard. Firstly, it is my submissions that all the witnesses who
have appeared before this Committee have been doing their best to assist, and I say that regardless of whether witnesses I have called on behalf of the GMC or whether they are the witnesses who my learned friend called on behalf of Dr Cosgrove. Nobody, you may think, has come here to lie or to pull the wool over the eyes of this Committee. People may have different viewpoints, those viewpoints may or may not be correct; their recollection of events may or may not be correct, but in my submission all who have come forward to give evidence have done so honestly. That, sir, will not detract from your need to assess the weight and reliability of that evidence – and when I deal with individual charges I will seek to point out respects in which, I submit, some evidence is clearly to be preferred to others.

Also at this stage of the journey, just returning to Dr Cosgrove’s statement for the moment, you will want to consider the manner in which evidence is put forward by witnesses. In respect of Dr Cosgrove’s statement that, you may think, is particularly important because, dealing as far as one can from a written statement as opposed to oral evidence, the manner in which Dr Cosgrove argues his case is in marked contrast to that in which other witnesses, particularly professional witnesses, have given evidence before this Committee. May I give two examples of that by contrasting Dr Cosgrove’s statement with first of all the evidence of Dr Moses and, secondly, the evidence of Professor Taylor?

Sir, you may think there is no question but that Dr Cosgrove had the interests of his patients at heart. He feels very strongly about it. His strong feelings may have led him into the situation in which he faces charges and admits charges of this nature, but you may think he undoubtedly seeks to act in the best interests of patients. Equally though, sir, you have heard from Dr Moses. Was she not also a doctor who was seeking to act in the best interests of patients? She has never suggested that Dr Cosgrove was not also so motivated. We have never suggested that, but you may think it is obvious from Dr Cosgrove’s statement that he does not share that view of Dr Moses. He does not hold the view that she has the best interests of patients in mind. He categorises her in a group of psychiatrists who, he expresses the view, have an arrogance, an egocentricity that blinds them to the facts and they are concerned only with their own reputations (says he). Is Dr Cosgrove in his statement bringing a balanced view here? We suggest not.

Contrast Dr Cosgrove with Professor Taylor. You might have been quite interested in Professor Taylor’s approach, because when he explained the spectrum about the ADHD diagnosis, about the use of medication for ADHD, you will see that in that spectrum Dr Cosgrove lies at one end of the spectrum and others – and perhaps this is true of Dr Moses, although I do not think we heard it put in this way but perhaps it is true of Dr Moses, that she is at the behavioural end of the spectrum rather than the medication end, if I can be as simplistic as to put it that way.

You will realise that Professor Taylor was way over to Dr Cosgrove’s end of the spectrum in terms of medication. Professor Taylor accepts though that there are different approaches and there is a role for clinicians to cover the problem in different ways and that there are different opinions, and that opinions may be valid, even those which he does not himself hold. He was, you may think, careful in his evidence, weight up arguments on both sides, making sensible and reasonable concessions when it was necessary to do so.
In contrast to that, Dr Cosgrove’s statement comes over in a dogmatic fashion, in my submission, accepting nothing other than that he is right and that anybody who disagrees with him is wrong. That is evidence, in my submission, about which you ought to be careful.

Finally by way of general comments on the issues of evidence, I just touch upon hearsay evidence really to anticipate what the learned Legal Assessor will advise you. You will no doubt listen to him with a great deal of respect. I urge you to exercise caution where the only evidence on a point is hearsay evidence; that is evidence from a person who has not given evidence before you, not been cross-examined before you. I urge you to exercise caution in respect of that evidence. There may be points which you find you can accept such evidence. It may be that it is difficult to accept such evidence, certainly to support a charge where we have to prove it beyond reasonable doubt unless that evidence is supported by other evidence, either unchallenged or where you have heard cross-examination and accepted that other evidence. That is by way of comment on issues of evidence.

In terms of categorisation of charges, it is perhaps helpful to have in mind the categories of issue that arise here. If I divide the allegations between those relating to prescribing and monitoring of medication in the one category and in the other category the criticism of other medics, taking those two categories separately, first of all in the medication category, the issues there break down themselves, I think, into two categories (I hope I get this right). The first is those where there is in fact an issue as to what happened, and there are some of those, particularly in respect of patient A, to which I will turn in due course. Secondly, there are those issues in respect of medication that relate to the judgement of that medication; whether what was happening with the medication, prescribing, monitoring, was appropriate.

In terms of criticisms of others, again we have the same breakdown of categories, do we not? The factual issues, essentially, is what we factually say that the charge is made out, and then there are issues of assessment as to whether what was said was inappropriate, unprofessional and unsustainable. As I go through the evidence, I hope I will be able to point to the aspects of evidence that support our case.

In terms of the factual issues relating to medication, most (but not all) are admitted – and I have indicated there are issues certainly about patient A. In respect of factual issues relating to criticisms, my understanding is at those points at which they are not admitted the issue is not essentially what was said but whether the charges correctly reflect what was said – and, again, I will deal with those in a little detail when we get to them.

May I turn to the issue of monitoring before I deal with individual charges? I want, if I may, now to begin to refer to the evidence in a little more detail.

In doing so I will give references to appropriate parts of documents and transcripts, with the exception, I regret to say, of yesterday’s transcript which I have not had an opportunity to look at. I will give you page references that hopefully permit us to proceed with some reasonable speed. In many respects I will not invite you to look at the documents now. If you have the references you most probably will have the points in
mind in any event. If you do not, if you have the references, I hope it will enable you to look at the appropriate documents in due course.

In terms of monitoring, can I refer you, first of all, to the European guidelines that Professor Taylor spoke of, then to Professor Taylor’s own writing and protocol on the subject and then to the additions that he had to say in the course of evidence. The European guidelines appear at page 296 of C10 and they are spoken of in the transcript for day 5, page 39, letters A to E.

Those guidelines, in my submission, emphasize three particular matters of relevance. The first is the physical monitoring of blood pressure and pulse every six months and on changing the dose; secondly, measures and recordings of height, weight and appetite on a six monthly basis and, thirdly, checks as to psychological or behavioural or psychiatric symptoms such as perseveration on a six monthly basis. That is published guidance that was available to Dr Cosgrove at the relevant time.

Professor Taylor’s own protocol appears in exhibit C10 at page 313 and was dealt with at some length by him in evidence on day 5 at page 30 G to page 32 D. Professor Taylor’s own protocol would suggest as follows: that one checks initial weight and cardiovascular status; secondly, that school reports are obtained at the outset; thirdly, that there is monitoring of weight, height and other physical features on a monthly basis for the first six months and then every six months thereafter; fourthly that school reports be obtained monthly for six months and then every six months thereafter; fifthly that the doctor with responsibility for the care should be reviewing the patient personally every six months.

In speaking of those guidelines, Professor Taylor amplified them by indicating that it was not sufficient to obtain information over the telephone. A share care scheme, for example, with a General Practitioner might be appropriate for physical monitoring and you will recall Professor Taylor was quite willing to accept that with some of the patients we are concerned with here it was perfectly appropriate to use a shared care scheme, but such a scheme needed to be properly set up and established. You may think it needed to have clear rules established as to where responsibilities lay.

Professor Taylor was also clear that this monitoring scheme was appropriate for the provision of Ritalin alone for dosages of up to about 16 mg per day. Polypharmacy, co-prescribing, the use of more than one drug at the same time and/or higher dosages would require more careful attention. They would require more careful attention in respect of the monitoring of behaviour and any psychiatric issues. One would be particularly concerned about symptoms such as perseveration, depression or hallucinations. The introduction of Risperidone itself requires proper cardiovascular monitoring, blood pressure, pulse and ECG.

Finally, on monitoring, Professor Taylor was keen to emphasize the need for there to be direct contact with the school, for school reports not to come via parents. It is important that we look at his reasoning for that a little further, because when we come to one of the patients this is an issue that is raised by Dr Cosgrove in his statement. Professor Taylor’s reasoning, you may think, is essentially two-fold in respect of this. The first is that if one obtains one’s school report from the parent, then one is dependent on what the school and how the school chooses to communicate with the parent. The school may, for example,
wish to emphasize the positive features of the child’s behaviour to a parent when that does not in fact genuinely reflect what is happening in the classroom. The danger there is that through teachers and other educational officers desire to communicate in a positive manner or in a particular manner they may mislead the parents.

The second is that the parents themselves might, when making their assessment of what is happening at school, pay too much attention to what is happening at home. You may recall Professor Taylor referred to evidence relating to this. Doctor Cosgrove suggests – and I will come to the relevant point in a moment – that this is about not trusting the parents and that there is some implicit criticism of parents in saying the school reports must come from the school, because you cannot trust parents, you may think it amounts to. That is not what Professor Taylor is saying. Clearly, when a parent has a child in his or her presence and company for weekends or evenings and when a parent hears of what has happened at school during the day, there is only a risk that the parent, entirely inadvertently, will put a gloss on any school report and will interpret what the school has said in the light of the parents’ own experiences. It is not to criticise parents. It is an aspect of the reality of one’s perception in a situation such as this. Again, Professor Taylor emphasises the good reasoning for contact with the school.

Sir, I have now completed dealing with general matters and I will turn to the individual charges. You may have the heads of charge before you and it is convenient for us just to run through them patient by patient if we may.

Head of charge 1 is admitted and we need not trouble ourselves with it. Head of charge 2, relating to Patient A, in respect of whom the witness you heard give evidence was Dr Holme. Of course, these charges relate to prescribing an increasing level of drugs to Patient A and to the monitoring and assessment that took place.

If I may deal with 2(b), none of which is admitted, first of all, might I deal with the figures referred to in 2(b) as to the levels and the fact of the prescription. In my submission, those details are supported by the evidence which you have heard in all cases, save for two inaccuracies that I will draw to your attention. The first is this: that the figure of 62.5 mg per day in (ii) appears wrongly. The evidence in the form of a letter from Dr Cosgrove to the General Practitioner, which is in exhibit C12, page 74, indicates that the dosage of Ritalin at that stage was 47.5 mg per day, in fact it having increased to 60 mg per day by November 1996. You will see that in exhibit C12, page 88.

The figures with which, for the purposes of the monitoring, we are particularly concerned with are the higher figures thereafter. A daily dosage of 100 mg per day is supported by the document at exhibit C4, page 128. One sees reference to prescription of Risperidone at 1 mg twice per day at that stage. As at 23 March 1998 the Ritalin dose appears to have been 110 mg per day. That is exhibit C12, page 73. The Risperidone dose was 2 mg per day. Finally, by May 1999 the Ritalin dose is 130 mg per day. The Risperidone is 2 mg per day and Clonidine is also being prescribed. That appears from exhibit C12, page 77. From those figures and those documents I trust you may make out which of those heads of charges are made out and which are not made out.

The material points are essentially, you may think, that it makes little difference for the purpose of assessing monitoring, which is the real nub of this matter, whether it was 47.5
or 62.5 per day and little difference whether it was 1 mg of Risperidone or 2 mg of Risperidone.

As I understand it, apart possibly from that detail Dr Cosgrove’s real argument in respect of head of charge 2(b) is that he was not prescribing the drugs and that it was the General Practitioner. That statement is made at paragraph 17.21 of his witness statement. Whilst it may be the case that it was the General Practitioner who was signing the prescription, you may think that it is utterly clear from the documentation that the General Practitioner, of whom no criticism is made by saying this, was signing the prescription at the level that Dr Cosgrove wished the General Practitioner to prescribed, as it were deferring to Dr Cosgrove.

If you look in exhibit C12, page 74, you will see from Dr Cosgrove’s own correspondence that this is exactly what he is doing. He is setting the levels and the General Practitioner, perhaps quite sensibly in the circumstances, was deferring to Dr Cosgrove’s knowledge, experience and expertise. Therefore, other than his not being the hand that actually signs the document, prescribing is exactly what Dr Cosgrove is doing.

Interestingly on this point, on this argument, it is perhaps worth nothing what Dr Cosgrove himself says about one of the other patients, that is Patient C. I will, if I may, read to you from his witness statement. Paragraphs 18.53 and 18.54, then 18.82. This is about Patient C, a patient where again it was the general practitioner who was signing the prescription.

“18.53:

Because the parents could simply not afford the cost of the medication, I asked the GP to prescribe the medication on the NHS. Nevertheless, it was necessary for me to monitor his progress on the medication, both the beneficial and side effects, so the first appointment I had with his parents was about ten days later.

18.54

After being on my prescribed medication for just ten days”

- that is my emphasis –

“his mother could report to me that aggression and abusiveness had completely gone. Patient C’s grandmother was now willing to have him stay over the weekend, something she had given up doing some eight months ago because of his dreadful conduct.

18.62

He remained well throughout the time he was under my care, with a good appetite and sleeping pattern. He was healthy the whole time with no dystonia, no dysconesia. He was able to manage in
mainstream school because of the medication I”
- my emphasis –

“was prescribing and was described as doing well there. He had
been saved by me from going to a residential special school.”

Essentially, you may think, what Dr Cosgrove is doing is, where it suits him to take
responsibility for the prescribing, to say, “Look at the wonderful things I was doing for
Patient C as a result of my prescription.” He claims the credit for prescribing it, but when
it suits him not to say so, he denies that he was prescribing it. In reality he was
prescribing, he was deciding the levels, he was monitoring. The general practitioner – of
whom I say again, no criticism made – was simply signing the documentation in order to
permit the patient to have the prescription on the NHS.

I turn to 2c, the monitoring of Patient A. There is no indication on any of the
documentation or in any of the evidence that you have heard, that Dr Cosgrove saw
Patient A between May 1996 and May 1999. There is every indication on the
documentation and from Dr Cosgrove’s own statement that he did not see the patient,
though he never expressly states that.

The letter that Dr Cosgrove wrote to the general practitioner, Exhibit C12 page 74, makes
reference only to telephone appointments following the initial appointment he made in
1996 and it is quite apparent from that letter that the prescription of Risperidone was
made without Dr Cosgrove having seen the patient after the initial appointment.

Dr Holme understood that Dr Cosgrove was not seeing the patient. Dr Cosgrove, perhaps
most tellingly in his witness statement, deals at paragraph 17.32 and 17.4, with the
reasons that he was not seeing the patient or his parents, relating to financial reasons –
understandable in their way, as long as the monitoring was adequate. It is quite clear, in
my submission, from that evidence that Dr Cosgrove was not seeing the patient. Yet,
Dr Holme made it utterly clear in his account in the witness box and in his letter to the
general practitioner – that is Exhibit C12 page 93 – that he, Dr Holme, was not
undertaking the responsibility of managing this prescription of Ritalin, still less any
subsequent prescription of Risperidone or Clonidine.

Professor Cosgrove’s case in his witness statement is summarised, I think, at paragraph
17.4 when he says – and I will just read it to you:

“I would like to re-emphasise again and again that Dr Holme was
monitoring Patient A’s growth and adequately assessing his weight
in Salisbury at the appointment that he himself booked with A’s
mother for A to be seen there.”

Clearly Professor Cosgrove was relying on Dr Holme to do some monitoring, not on the
face of that part of the statement or, as I see it, the rest of the statement, was he expecting
him to monitor, for example, the psychiatric side effects. Of course, if those had arisen
and been obvious to Dr Holme he might have referred to them but there was no
arrangement about that and, even that which is referred to – growth and weight – is
inadequate for the kind of monitoring Professor Taylor considers appropriate, cardiovascular, ECG, matters of that nature.

Where is the review of school reports? It is clear from what Dr Cosgrove has to say in one of the enclosures to his statement – and this is enclosure I, paragraph 4.30 to 4.32 – that is a document, if you recall it, headed, “Response to the letter from Dr Christopher Holme, consultant community paediatrician.”

It is apparent from paragraphs 4.30 and 4.32, that Dr Cosgrove was not contacting the school. In justification of this or in criticism of Dr Holme for apparently having suggested that Dr Cosgrove should have been in contact with the school, he criticises Dr Holme for saying that mothers should not be trusted to report what schools say to them about their sons’ progress.

That is the point I was making earlier. This is not a matter of trust; it is a matter of getting accurate information that is not filtered through the point of view of another person who, for a variety of reasons, may not receive the information accurately or may not communicate it accurately. It is not a question of trust, but it is clear from that statement that Dr Cosgrove was not contacting the school.

Dr Holme was not purporting to monitor the psychiatric condition. Professor Taylor emphasised the importance of this, in particular at the very high dosages with which we are concerned here.

These were very high dosages. Professor Taylor, who is an expert who, you may think, is more willing than many to prescribe drugs such as Ritalin, has never prescribed at this kind of dosage. Nor, in my submission, does any of the literature that we have heard, whether it be Professor Taylor’s or that put to Professor Taylor, on the interpretation we have of it, support a prescription of anything like this kind of level. That is not to say it is wrong. It is not charged as being wrong; we are not saying it is wrong. It is to say that in those circumstances monitoring is particularly important.

In Patient A’s case, if I may say so, monitoring was particularly lax. Even the initial measuring of Patient A’s weight appears to have been faulty. We have heard from Mrs C and Mrs E that Dr Cosgrove or possibly a nurse – I know not which and it does not matter for these purposes – measured the weight of their child. I do not dispute that, they said in evidence and I did not challenge them on the accuracy. It is quite clear from the documentation that Dr Cosgrove did not measure Patient A’s weight. He says as much. He makes the error of the centile in which the weight lies and in so saying says that he was told the weight lay in the 50th centile. So, Dr Cosgrove was clearly relying upon that which he was told, which may have been misinterpreted but does rather beg the question, you may think, as to whether what happened here was that Dr Cosgrove asked somebody, presumably mother, “How heavy is he?” and did the parent reply, “He is on the 50th centile” or did the parent reply, “He weighs X” and Dr Cosgrove translated that to the 50th centile? We do not know. You might think it is almost certainly one or the other but either way, this is lax. This is lax practice even, you may think, on the standards that Dr Cosgrove himself sets in terms of appropriate monitoring.

Then what of the measuring of blood pressure in this case? You will recall that this...
patient developed tachycardia and we see in Exhibit C12, to which I will just refer for accuracy’s sake, C12 pages 68 and 69, Dr Cosgrove’s letter when this is drawn to his attention. In the third paragraph, page 68:

“I asked his mother to try taking his pulse and it would appear that she does not find this too easy so that her previous readings of 60 and always less than 100 are unreliable.”

This is poor monitoring on any version of events, to expect a mother who clearly, on this evidence, was not in fact able accurately to record pulse, to do so is, you may think, a matter of great concern. Interestingly – and I do not criticise this in point of fact, but interestingly – what is then suggested by Dr Cosgrove is that Patient A’s godmother should monitor the pulse rate. She is a nursing sister. She is clearly qualified to do it and, as I say, I do not criticise that suggestion at all, but it perhaps demonstrates how in Patient A’s case monitoring was being anticipated was taking place and, for example, the extent to which Dr Cosgrove was relying upon Dr Holme, the extent to which he was relying upon that information that came from the family.

Sir, dealing with (iv) of 2c in respect of Patient A, the withdrawal of Clonidine, it is, you may think, quite apparent that no warning was given about this. It is apparent from Dr Cosgrove’s statement that he does not think there is any risk of the withdrawal of Clonidine having a deleterious effect on Patient A’s blood pressure, because he says as much in his witness statement in enclosure I at paragraph 7.11 to 7.13. He speaks of the rebound effect and says essentially that that will only happen in a patient who is taking this drug for hypertension.

Other witnesses have expressed concern about this, particularly Professor Taylor. It is clearly a risk. It is a risk, in my submission, of which Dr Cosgrove should have been warning the general practitioner.

Finally in respect of patient A, to say this of Dr Holme’s position. He was, you may think, a careful, caring doctor. He was carrying out his duty as a paediatrician to see this child on a six monthly basis. It is perfectly understandable that in so doing he should measure weight and height, he should record blood pressure, he should look for any reported signs and any apparent signs of any problems with this patient, but to say that thereby Dr Cosgrove could effectively delegate the monitoring without any clear arrangement, without it being clear to Dr Holme what was expected of him is, in our submission, simply not acceptable. Professor Taylor made it clear an ordinary paediatrician, albeit a consultant paediatrician, cannot be expected to have the knowledge and experience necessary for this kind of monitoring.

I move on, if I may, to Patient B. The relevant charge is charge 3. the witnesses from whom you have heard are Dr Al Shabdner and Dr Humphreys. These, of course, are charges relating to criticising other doctors.

Looking at 3c, the non-admissions in respect of 3c, relate to the contents of the letter and are, you may think, essentially grammatical in nature in the sense that what is being said on behalf of Dr Cosgrove was that the letter says not that the doctor whom he had been to see had been rude and unhelpful but that Dr Cosgrove had been told that the doctor who
was being seen had been rude and unhelpful. I ask you to read that letter; you will make your own judgment as to what is being said by Dr Cosgrove in the letter and as to whether he himself is adopting and associating himself with the comments that apparently come from Mr B. I invite you to say that he is doing so.

In point of fact, justified or unjustified, accurate or inaccurate, as to whether what Mr B found, what Mr B told Dr Cosgrove or whatever, you may think that those two matters are not part of this charge anyway and it is the criticism of the doctor as being guilty of medical negligence, as demonstrating professional incompetence, and Dr Cosgrove does, by admitting 3c(v) and (vi) is adopting those allegations. He is not simply saying “Mr B told me that this doctor was negligent”, he was saying “This doctor was negligent. This doctor was incompetent”.

Fairly sensibly and realistically, it is admitted on Dr Cosgrove’s behalf that those comments were likely to cause the reader to doubt Dr Al-Shabner’s knowledge and/or skills. They clearly were likely to do so. Were they unprofessional? Were they unsustainable? You have heard what Dr Al-Shabner had to say about that consultation. He denied the criticisms that had been made; he denied that he saw no role for the diagnosis of ADHD in an adult; he indicated that further investigations were required before a proper diagnosis could be made in that patient’s case. Whatever the patient may have had to say to Dr Cosgrove there was a real risk here, and a risk which we say came to pass, that in making criticisms of this kind Dr Cosgrove was saying things which were not in fact accurate and which were likely to interfere with the proper care of patients.

Dr Cosgrove has taken what Mr B says at face value, apparently; he has then adopted those comments and used them to make wide disparaging comments of Dr Al-Shabner. At paragraph 14.1 of his written statement, Dr Cosgrove makes clear that he still considers this doctor to be guilty of medical negligence. This is not acting as an advocate for patients – a matter which I will touch upon a little later in my submission. This, in my submission, is Dr Cosgrove advocating his own superiority or belief in his superiority to other psychiatrists in their approach to issues such as ADHD.

I have readily accepted, and do readily accept, that robust criticism has a strong and proper place in the medical system. Strong comments are made and that can be perfectly proper. But this goes well beyond what amounts to proper criticism. These are comments made in ignorance of the true situation in a manner that is likely to make it more difficult for this particular doctor, Dr Al-Shabner, to carry out his professional tasks because Mr and Mrs B, to whom a copy of the letter is sent, are being told that Dr Cosgrove thinks Dr Al-Shabner is guilty of medical negligence – information that they can themselves take account of and disseminate to anyone else they wish to do so.

A general practitioner receives the letter. What is he to make of this? Is he supposed to say, “A consultant is telling me that this particular doctor, with whom I have a working relationship is negligence. I shall not use that doctor any more”? What is the general practitioner to make of Dr Cosgrove’s position? Is the general practitioner to think “I am not happy for patients to be referred to Dr Cosgrove because when I refer them to Dr Cosgrove I receive a letter that is critical and goes to a patient” – critical of Dr Moses. In all manners this interferes with the proper, you may think, medical care and treatment of patients.
I have referred to the passages from *Good Medical Practice*, notwithstanding our debate about the page numbers. This criticism clearly offends against that, in our submission, and in common sense it offends against proper team working and proper medical care.

I indicated earlier that from Dr Cosgrove’s witness statement one could derive certain ideas as to what his approach to criticism of other doctors is. I will, if you will just excuse me, just read through paragraph 14.5 and 14.6 of the witness statement so you can see something of how Dr Cosgrove seeks to justify and explain his criticisms. This is directed to the Preliminary Proceedings Committee, for reasons that are perfectly understandable:

“Members of the PCC, if you disagree with what I have said in private about and to Dr Al-Shabner, then I will have no alternative to believe that you do not care about Mr B’s experience of Dr Al-Shabner, both as a person and as a psychiatrist. I will conclude that you care more about Dr Al-Shabner’s hurt feelings than you do about Mr B’s hurt feelings. I will realise that you are in power for the protection of psychiatrists in their clinical practice – as long as they do not commit an act against a patient of which a society itself would disapprove – and not for the protection of patients.

It is axiomatic in our society that ignorance of the law is no protection from being disciplined by the law. It must be axiomatic also that ignorance of a disorder (ADHD), which is common and which does occur in adults according to the ICD10 & DSM4 international classifications, is no protection from being disciplined by those who govern the professional conduct of psychiatrists. If you find in favour of Dr Al-Shabner and not me, then you will be officially condoning ignorance of a disorder which he should have known about, and you will be doing a grave disservice to the citizens of this country.”

I say be careful with the tone of this. It is strong. Do not necessarily hold it against Dr Cosgrove – save this, that does this not really amount to battle lines? There were two sides to this. You are either on Dr Cosgrove’s side, you agree with him and you agree that his way of doing it is the way of doing it, or you are on the other side of the line and you do not agree with Dr Cosgrove, in which case you are ignorant, you are doing a grave disservice to other people, you are not caring for patients. It is as simply as black and white, as straightforward as that, in Dr Cosgrove’s view. When one reads passages like that, the reasoning behind that, it perhaps comes as no surprise to see Dr Cosgrove making criticisms of this nature. But can that truly be sustained? Is that truly a professional way to act? We say clearly not.

You will have noted Professor Taylor’s comments about Dr Cosgrove’s own letter in division 3 of the bundle and his characterisation of ADHD; his mention of there being four elements, including motivation, what he has to say about dopaminergics and suchlike. Professor Taylor considers that the contents of this letter do not represent
conventional medical thinking. Perhaps the passage of time will prove Dr Cosgrove to be right on his understanding of this condition, but it is clearly the case that there are different schools of thought, at the very least, and that Dr Cosgrove fails to recognise that in what he has to say about unprofessionalism.

May I turn to patient C, charges 4 and 5, in respect of whom you heard from Dr Moses and you heard from Mrs C? Charge 4 relates to monitoring, charge 5 relates to criticism. Dr Moses gave evidence on Thursday of last week. She was, you may think, eminently sensible and balanced in her approach. She maintains that her team had thought of ADHD as a diagnosis but were not convinced that was correct; they took a behavioural management approach. You will have noted from Professor Taylor’s evidence that there were different schools of thought on the role of behavioural management but that behavioural techniques are important – important often in conjunction with the use of medication. You will have noted Professor Taylor’s comments yesterday, that he feels a great deal was done for this patient at the unit; it might not have been done in the way that Dr Cosgrove would have liked but a great deal was done for the patient.

You will have noted from Dr Cosgrove’s statement at paragraph 20.23 that he describes Dr Moses as having “insufferable egocentricity”. Is that right? Is that how you found her last week? In my submission, she was not so, either in her behaviour, in her explanations, nor in any sensible view as to what happened.

In terms of the monitoring charge, it was clear from what Professor Taylor had to say that proper communication between consultation prescribing and recommending in situations such as this on the one hand and general practitioner carrying out monitoring is of vital importance. We do not have any documentation that indicates there was a written protocol or written arrangement for monitoring in that case. There should have been some clear protocol arrangement. We have already seen in the case of patient A what can happen if doctors are at the very least at cross purposes as to how monitoring is taking place. We do not know, for example, what was said about measuring different cardiovascular issues in this case, notwithstanding the fact that Risperidone was being prescribed. So, in our submission, although the monitoring charge is not admitted, paragraph 4e is clearly made out.

In terms of the criticisms at charge 5, the only one not admitted, 5b(ii) is again, I think (if I can put it this way) a grammatical issue. My learned friend will, I understand it, contend that the letter says Dr Cosgrove is not saying that Dr Moses had seen Master C only once, Dr Cosgrove is saying that Mrs C had told him that Dr Moses had seen Master C only once. I invite you to read that letter and, if you do so, it is, in my submission, utterly apparent that Dr Cosgrove is adopting precisely this criticism; he himself is asserting it, he is not simply passing on what someone else has to say.

What happened in the middle of 1998 in respect of patient C did in fact lead to a breakdown of medical care, in my submission. It was not this letter that caused it in point of fact, it was previously the fact that patient C was seen by Dr Cosgrove that a diagnosis of ADHD was made and that patient C returned to the clinic saying “I have ADHD” as if that justified everything. Here there was, in my submission, a clear failure of team working by Dr Cosgrove. His involvement might have been justified, his prescription might have been correct, but to do that without working jointly with those who had care
already for Master C was, in our submission, inappropriate. This is not simply a case of saying that everything went terribly well once Dr Cosgrove took over. As Professor Taylor says, behavioural therapy techniques are almost always required in addition to medication. Here was one up and running with Dr Moses doing a great deal for patient C, destroyed, you may think, by Dr Cosgrove’s approach – and if it had not been destroyed by what he said in the consultation it would have almost certainly have been destroyed by this letter, seen by parents, that would have caused them greatly to doubt Dr Moses’ competences and abilities.

I said at the outset that in my submission all witness came to assist the Committee and to tell the truth and were honest, even if not necessarily accurate in their recollection. Mrs C, in my submission, falls very much into that category. Her evidence was unsatisfactory in this sense – and this is not a criticism of her, in any way, shape or form. One is dealing with matters a significant time ago in respect of which she did not have records before her. She asserted facts in a dogmatic fashion as to how many times and in what circumstances Dr Moses had seen her son. She had no documents to support this. She said, for example, that Dr Moses had only seen her son once; that Dr Moses was not attending on that unit. How could she have known that? She may suspect it but how could she have known that?

She said, and maintained, that Dr Moses had said that her son would be better off in a children’s home. You may have noted through reading Dr Cosgrove’s statement that nowhere does he make that allegation; nowhere does he mention Dr Moses is supposed to have said this. He does mention the possibility of residential schooling, that this had been raised. He actually said it was raised by the local education authority, not Dr Moses. It may be, you think, that Mrs C does not perhaps know much about the education system and social care, that Mrs C may have been confused between residential schools and children’s homes – but nowhere is this attributed to Dr Moses, it is attributed to the local education authority. Yet if Mrs C had these concerns and shared these concerns with Dr Cosgrove, it is inconceivable, is it not, that one of her concerns would not have been “What will Dr Moses say? That my child should be in a children’s home? It is outrageous” or words to that effect. If that had been said by Dr Moses, it would have been in Dr Cosgrove’s letters, it would have been in his statement – but he never said that.

As I indicated, there is room to understand how Mrs C might be confused between a residential school and a children’s home. There is absolutely room to understand how, with the passage of time, Mrs C might be confused about who it was who said it. You can be, in my submission, quite satisfied that this was not a comment made by Dr Moses. It was not in her style, you may think, having heard from her, to speak in this kind of way.

I have no doubt that Mrs C, in giving her evidence, genuinely agrees with the criticisms that were made by Dr Cosgrove in this letter. Her genuine belief in them does not, in my submission, for a moment excuse Dr Cosgrove writing a letter of this nature. It does not make this letter sustainable, it does not make this letter professional. Again, this kind of letter will only act to undermine patient/doctor relationships. How could Mrs C, if she had any confidence in Dr Moses in July 1999, before she saw this letter, continue to do so after she saw this letter?
Is the answer, and I think this is the answer Dr Cosgrove would put, in terms of his statement, that she already had no confidence. “I am simply recording what she had to say.” Was that truly the case or was Dr Cosgrove not giving some kind of credibility to concerns Mrs C herself may have had and turning those doubts and concerns into, as it were, established fact in her mind? We will see when we come to Mrs E, Wendy Samways and the complaint in respect of the Oxfordshire Mental Health Care Trust how, in my submission, the evidence supports the fact that Dr Cosgrove’s criticisms snowball into persuading parents that all is not well with care.

One other aspect of what Dr Cosgrove has to say in respect of this patient deserves a mention. That is paragraph 18.74 of the statement and I will read it to you. It is one short sentence,

“Mrs C has now developed angina through all this NHS care of her son.”

You may wonder what Dr Cosgrove’s basis for saying that is in the statement. Is he again putting issues in a black and white sense, your are with him or you are against him? In my submissions, the criticisms that we set out in respect of Patient C are clearly made out.

Patient D, from whose mother we heard, we can be very short with indeed. The allegation is one that the examination was inadequate, in that Dr Cosgrove did not weigh or take this patient’s blood pressure. It was a short consultation. You heard from his mother. His mother gave her evidence clearly on this point. There is no evidence to contradict this and, in my submission, that allegation is most clearly made out. Again, it is apparent, from the course of what happened with Patient D, that there were no proper arrangements made for monitoring the treatment. I do not think I need to repeat what I have said already about the necessary and appropriate monitoring.

I will move, if I may, to charges 7 and 8, which relate to Patient E. The relevant witnesses from whom you heard were Mrs Samways and Mrs E. From Mrs Samways’ point of view, it is clear from her dealing with the parents that they were happy with the investigation process. Of course, they had a complaint. They were complaining, but the process they had no complaint about, until Dr Cosgrove became involved and she knew nothing of any complaint until she read that letter from Dr Cosgrove.

You heard from Mrs E on Tuesday. Mrs E is clearly concerned for the welfare of her child, and understandably so. She, if I may say so, clearly believed strongly in what she was saying. She was not lying to this Committee and I do not suggest that for a moment. She accepts that she had expressed no concern about this investigation process before Dr Cosgrove’s letter was sent to her. She had consented to the disclosure of notes. She had not revoked such consent. She had agreed, and you may think from her evidence, was keen to have a review. She had not suggested that she had changed her mind.

She said in evidence that from speaking to the Community Health Care and so on, doubts had been put in her mind. But, when one actually looks at the contents of Dr Cosgrove’s letter, one may wonder how she can have had any of the doubts that he speaks of without
him having expressed those to her. He says that Dr Kenyon was not sufficiently independent to do justice to this inquiry. What is the source of that information? Who is it who makes this criticism of Dr Kenyon? You may think it is utterly apparent from the correspondence that that is Dr Cosgrove’s criticism. Dr Kenyon was insufficiently expert to conduct such an inquiry whilst Dr Cosgrove was, in essence, sufficiently expert to do so. You may think, again looking at the tone of the letters from Dr Cosgrove, that that was a criticism that clearly came from him.

That the investigation was programmed, in the words of the letter, to ensure that the Trust would come out with a clean bill of health. Mrs E never said she had expressed a view of that nature and, indeed, until this stage had been happy for this kind of review to take place. The inquiry would be a whitewash. She said about that that it did in fact turn out, in her view, to be a whitewash. What may be happening here is that one has a process of Dr Cosgrove expressing his view, the review taking place, Mrs E not being satisfied with the outcome, rightly or wrongly I do not know, but then adopting the criticism that Dr Cosgrove made at the time. But were these criticisms she herself had?

Perhaps it is interesting to note that one of the documents enclosed in with Dr Cosgrove’s statement is a letter from Mrs E to the General Medical Council in July 2001. One of the things it says, and this is enclosure E, a typed letter,

“Dr Cosgrove has not in any way distressed our family. Quite the opposite. We are grateful now…”

my emphasis,

“…that Dr Cosgrove has not sent out Patient E’s records, not out of mischief making but out of support for our cause.”

Her use of the word “now” may make you think that it was only after the event that she was glad that Dr Cosgrove had not sent all the records. It was certainly not something that she knew about, consented to or encouraged at the time.

In our submission, the conduct of Dr Cosgrove here was inconsistent with this review taking place in the appropriate manner, that it was he and not Mrs E who was blocking the progression of the review by not supplying notes and that he ought to have been willing so to supply them. His criticisms thereafter of the inquiry and what it would involve is perhaps anticipating that his position in this black and white world that he sees will not be made out cannot, in our submission, be justified.

Yet again, Dr Cosgrove shows a failure to work in a team with other health professionals. He indicates that he is acting as an advocate in one case. It does not actually relate to this patient. Paragraph 15.97 is interesting reading when you seek to assess these comments made by Dr Cosgrove and whether they are justified,

“What is wrong with me acting, not only as…”

that particular patient’s,
“...consultant psychiatrist but also as his ADVOCATE in regard to what I considered to be incompetent diagnosing, treating and professional misconduct towards this innocent and helpless psychiatric patient. I believe that as a fellow citizen of the UK alongside the patient, I have a right and a duty to formally complain about what I, as a skilled and caring psychiatrist, perceive to be serious professional misconduct on the part of...”

the doctors in that particular case.

Like all advocates, if I may say so as one myself, the danger comes when there is a blurring of lines between the advocate advancing a case on the one hand and expressing a personal view on the other hand. Those are lines that Dr Cosgrove has repeatedly crossed and, in so doing, has in our submission caused damage to the relationship between patient and doctor and has caused difficulty in proper medical care for patients.

I move on to Patient F. The relevant heads of charge are under paragraph 9 and this relates to criticisms of colleagues, Dr Chubb and Dr Thomas. We heard from Dr Thomas. Dr Chubb’s witness statement was read. I have already expressed caution about you taking witness statements where the author has not been cross-examined, save and except where that evidence is consistent with evidence of witnesses from whom you have heard. You have heard from Dr Thomas and you may think there is a consistency that allows you to accept what Dr Chubb says as well.

These are strong criticisms from Dr Cosgrove. Having heard from Dr Thomas herself, you may conclude that the criticisms that are being made simply cannot be justified.

Was Dr Thomas competent? Frankly, even if she was not competent, you may think these are quite unjustifiable, unprofessional and unsustainable comments. In fact, you heard from her. You heard her explanation as to her role and the fact that she went to speak to Dr Chubb, what they were considering in terms of further investigation in this case. They were considering a diagnosis. They had not rejected ADHD. They were considering referring the matter to somebody who was more expert in ADHD in adults. Was she in fact guilty of any negligence? Not for a moment, you may think.

Did she make the problem of ADHD as a concentration problem for messy kids? You heard her give evidence. You saw the kind of person she was. Did she make a comment of that nature? She denies it. You may think she very clearly did not.

The only factual part of head of charge 9 which is disputed, as I understand it is ©(ii), whether Dr Thomas had made that statement. Again, if you look at the letter you will, in my submission, conclude that Dr Cosgrove is indeed saying that Dr Thomas had made that statement, not just that he had been told that. If you have any doubt about that at all,
can I refer you to paragraph 15.94 of Dr Cosgrove’s statement when he says this,

“Well, I accept Mr F’s statement that Dr Thomas DID say that ‘concentration problem is for messy kids’ and that ‘the consultant thinks you have a personality disorder which is untreatable.’ I am confident that nothing I have stated as a quote from Mr F is wrong or incorrect. I do not believe that Mr F is lying. It is just the sort of comment that a psychiatrist would make to a patient when that psychiatrist does not know about nor believe that ADHD occurs in adults, and when that psychiatrist is face to face with a patient who has asked whether he might have ADHD which he has read about for poor concentration is one of the four major characteristics of ADHD. To respond by saying that ‘a concentration problem is for messy kids’ is a totally appropriate and contextual comment for a psychiatrist to make in order to dismiss the diagnosis of ADHD.”

He clearly is adopting the comment there. What does he say in his statement of Dr Thomas? He says this at paragraph 15.93,

“Of course, Dr Thomas will make a statement to the effect that she did not say to Mr F that ‘concentration problem is for messy kids’ and that ‘the Consultant thinks you have a personality disorder which is untreatable.’ And she will believe that society will accept her version of what happened in that consulting room, because psychiatric patients cannot be trusted, especially those who have just been given a diagnosis of personality disorder. The psychiatrist is ALWAYS right in what she says and what she does, and the psychiatric patient is ALWAYS wrong.”

Again, I am afraid we have Dr Cosgrove painting things in the most black and white fashion. There is material in the form of a signed statement from Mr F saying that these things were said. No doubt that is a genuine statement by Mr F. I am not for a moment saying that somebody in whom a diagnosis of personality disorder has been, rightly or wrongly, cannot be trusted to give evidence. That would clearly be nonsense. Dr Cosgrove is seeking to paint things wholly unrealistically in a black and white fashion.

You have heard Dr Thomas give her evidence. You have been able to assess what she has to say on this. You have not had an opportunity of assessing what Mr F had to say, whether, for example, he might have confused something that was said to him on another occasion by someone else, whether he might have confused things that he had read about being said of ADHD. One simply does not know. What one does have is Dr Thomas’s evidence, which, in my submission, was consistent and powerful.

Patient G, paragraph 10. These are allegations relating to prescription and monitoring. You heard evidence from Dr Judge on this point. You may think that the evidence is clear, both as to the levels of prescription, but in any event it is admitted that both Ritalin and Risperidone were prescribed, and, secondly, that the only monitoring that took place was by telephone. Yet this was in a four year old child. Again, Professor Taylor does not criticise the prescription of Ritalin in a four year old child, although I think many medics would not do it themselves. He does not criticise it. We do not criticise it. It is acceptable, so long as there is proper monitoring.

There was not proper monitoring here. He lost weight after this prescription started.
Risperidone was prescribed on the first consultation, yet there was no ECG and there was no follow up by Dr Cosgrove himself, save by telephone, which may be adequate review in certain circumstances. It most certainly was not in these.

Patient H. Charge 11 refers to this. There is an admission of the factual background to these criticisms. There is an admission that what was said, and this is Dr Dover, was likely to cause the reader to doubt the knowledge and skills of Dr Dover. This is the one charge in respect of which I have called no evidence from a witness before you, because Dr Dover was read. I accept that my comments on hearsay evidence here rebound to say that you must take what Dr Dover says with a deal of salt, given that he has not been cross-examined in front of you. On the other hand, most of what is here is actually admitted and it is a matter of inference and judgment from the evidence.

In the second place, there is in fact no evidence contradicting what Dr Dover has to say. You may think, in the absence of evidence contradicting him, and in the absence of evidence to justify what was said in that letter, that you have no difficulty that (d)(i) and (ii) of paragraph 11 of the heads of charge are made out.

I return to my general comments. Dr Cosgrove has, in my submission, painted a picture or has in his mind a picture of a black and white world, of people being on his side or against him and if they are against him, then he considers any criticism to be justified, regardless of how that may affect therapeutic relationships. That conduct, for the purposes of matters that you are considering at the moment and at this stage of the proceedings, is, in our submission, clearly sufficient potentially to amount to serious professional misconduct. It is so sufficient potentially, even on the doctor’s own admissions that he has repeatedly in the statement and in letters made comments that are likely to cause readers to doubt the knowledge and skills of doctors, and that he has done so in letters. He describes them in the passage I read earlier as being made privately. They were not made privately. They were made in letters copies to parents, to other medics and in a manner that was likely to lead information to be passed on or, at the very least, to affect therapeutic relationships. That conduct, for the purpose of these charges, cannot, in our submission, be justified or sustained. It is unprofessional.

Sir, unless I can assist the Committee further, those are my submissions.

THE CHAIRMAN: Thank you very much, Mr Pearce. I wanted to check with you. In charge 2 I think you indicated that there may be some errors in the figures in some of these heads.

MR PEARCE: Yes.

THE CHAIRMAN: Is it my understanding that these heads of charge are not being amended?

MR PEARCE: I was not proposing to amend them, sir, simply for this reason, that if I make out the point on prescribing, then in my submission the other heads are clearly there and 47.5 as against 62.5 will not, in our case, make any difference to your assessment of the issues. It is not central to the issue and it did not seem to me in that circumstance that it was necessary for me to seek to amend it.
I appreciate that the implication of that is that you will not find for me on those heads. I do understand that. I do not invite you to find for me, notwithstanding the fact that I have said the evidence does not support it.

THE CHAIRMAN: I think the Legal Assessor wants to say something.

THE LEGAL ASSESSOR: Can I just raise the point about the inferences that may be drawn from Dr Cosgrove’s failure to give evidence. Can I indicate here and now that my instinct, if you like, is to say that no inferences – or certainly not adverse inferences – should be drawn on that failure in the circumstances of this case.

The difficulty that I have is that as regards the criminal rules of evidence, if I can draw your attention to Section 35(3) of the Criminal Justice and Public Order Act 1994, Section 35. That reads:

“Where this sub-section applies, the court or jury”

- and for that I interpose the Committee –

“in determining whether the accused is guilty of the offence charged, may draw such inferences as appear proper from the failure of the accused to give evidence, or his failure without good cause to answer any questions.”

Now, the law is hard stuff when it is written down. What do you say about that section?

MR PEARCE: I say that you should not draw inferences against the doctor in these circumstances. There may be circumstances, possibly before this Committee, certainly there may be circumstances in criminal cases, where a body may take the view that an inference can be drawn that the reason the doctor – the Defendant – has not given evidence is that they are guilty and they have got no answer to the charges, for example, or that they do not want to put themselves through the process of being cross-examined. These are the kinds of arguments that may arise.

In the circumstances of this case, given that Dr Cosgrove has not been present through this part of the proceedings, that really, you might think, would be a difficult inference to draw in any manner that allowed you to be satisfied so that you are sure on any of the points with which we are concerned.

There are other explanations to why Dr Cosgrove might not be here that are perfectly valid and possibly more valid than that he believes that he has not got a defence to these charges. Indeed, that which we have got in his statement suggests he believes he does have a defence to the charges, so it is not an inference I would seek to draw and I hope I have not suggested that I would invite you to draw such an inference, because I was not meaning to do so.

THE LEGAL ASSESSOR: I do not want to put words into your mouth but can I summarise it this way, that you accept that Section 35 exists and is applicable but, in the
particular circumstances of this case, you are content for me to advise that no inference – and certainly no adverse inference – should be drawn as to why he has chosen not to give evidence?

MR PEARCE: Indeed so. Indeed, so, sir. I am quite happy with that. Of course, the fact that he has not answered some of the charges is not – I am not saying that that tends to prove that he is guilty of those charges. It simply does not assist you in dealing with those charges but that, of course, is a separate point, a technicality.

THE LEGAL ASSESSOR: I am grateful for that. I could not just ignore the express words of the Statute. I hope you understand that.

MR PEARCE: I understand, sir.

THE LEGAL ASSESSOR: Can I just briefly turn to Mr Morris and see if he is content with that position?

MR MORRIS: Sir, I think I would go a little further and say I would submit that Section 35 does not apply because for it to apply there has to be a refusal by the doctor to give evidence. I hope I have got it right.

THE LEGAL ASSESSOR: The actual words, if I can read it to you, are, sub-section 3:

"Where this sub-section applies the court or jury in determining whether the accused is guilty of the offence charged, may draw such inferences as appear proper from the failure of the accused to give evidence or his refusal."

- I think that is what you were thinking –

"without good cause to answer any questions."

Can I just say, are you content with the position that I have outlined with Mr Pearce?

MR MORRIS: Yes, indeed so, sir.

THE LEGAL ASSESSOR: I am grateful.

THE CHAIRMAN: I think it would be appropriate if we had a short break just now and take your submissions after the break, so we will come back at just after 11.30.

(The Committee adjourned for a short time)

MR MORRIS: Sir, may I start by gratefully adopting what Mr Pearce said to you by way of opening general comments in relation to the general approach to evidence that you ought to adopt, in particular in relation to documentary witness statements that have been put before you by both sides. Also, the warning he uttered about making improper inferences from the tone of Dr Cosgrove’s statement, which was written for the purposes, as can be clearly seen, of the Preliminary Proceedings Committee.
May I add an additional caution, which is that we are at this stage – I say “we”, that is presumptuous; you are at this stage – dealing with findings of fact that have to be made in relation to the particular heads of charges that have not been admitted. I do caution that it is necessary to confine yourselves at this stage to those heads of charges as they are drafted to see whether the evidence is such that you can be sure that they are established as facts.

It may be that my learned friend in addressing you in relation to these matters, has strayed into and submitted in relation to matters that do not go directly or indirectly to the particular heads of charge with which you are concerned. It may very well be that some of the submissions he made would be perfectly appropriate at the next stage of these proceedings, if and when we arrive at that stage.

May I give you an example where I think caution is called for. In relation to Patient A, he tells you that Dr Cosgrove was not contacting the school directly and that therefore he fell outwith the guidance promulgated by Professor Taylor.

There is no head of charge relating to that issue. Similarly, in relation to the issue of the taking of blood pressure of Patient A, there is no head of charge which suggests failure to measure blood pressure by Dr Cosgrove was irresponsible monitoring.

No doubt both those matters would be of significance and relevance when it comes to considering the circumstances leading up to any facts that are found proved or admitted at the next stage. At this stage, I submit that they have no relevance and should be put out of your mind.

Similarly, by way of final example, in relation to Patient C, where my learned friend talked about there having been a breakdown in medical care not caused by the letter that was written and which is, effectively the sole subject – or is the sole subject - of head of charge 5 in relation to which it is suggested that the comments he made there were unprofessional, unsustainable, likely to cause the reader to doubt Dr Moses’ knowledge and skill.

What effect Dr Cosgrove’s earlier consultation with the patient and the patient’s mother – and perhaps father – in relation to the continuation of medical care at the unit and the fact that apparently the child had returned to the unit and said, “There is no point in my undergoing what you are suggesting because I have got ADHD and your proposed treatment will not help. It is suggested that that is an indication of the failure of joint working, continuum working, between different clinicians.

Again, in my submission, at this stage, it is not relevant to the matter in hand which is the question of the letter and the significance of that letter.

Can I, then, turn to the heads of charge and the outstanding non-admitted facts which you will have to decide whether or not are proved.

In relation to Patient A – and I take the patients sequentially – head of charge 2, my learned friend is right when he says that really the issue here behind the non-admissions
relates to the question of whether or not there was as prescription by Dr Cosgrove or a recommendation for a prescription. It is somewhat, I concede, a technical submission on Dr Cosgrove’s behalf that I make, but it does have some substantive effect, in my submission.

That he was not actually prescribing, I would submit, is made out in the last paragraph of the letter that he wrote in this regard. It is at C12 page 72. I do not ask you to turn it up. I will read it to you:

“I have made out a private prescription for Ritalin but I know that his parents would very much appreciate it if you would copy it down on to an NHS scrip. On each occasion that I alter the dosage I will send them a fresh private prescription to bring to you. You may care to keep them in his file.”

He also sets out that in his witness statement, as Mr Pearce told you, at 17.21.

The significance between him actually issuing a prescription with the intention that the patient or the patient’s parents should get that dispensed and sending it to the general practitioner, not only in my submission is one of trying to assist the patient or patient’s parents financially, but there is also this significance inasmuch as the invitation to the general practitioner to issue the prescription on the NHS imports automatically an obligation on that practitioner to exercise his or her own independent judgment before agreeing to copy the prescription as recommended by the doctor. That will have some bearing in relation to head of charge 2c.

I say no more about the inaccuracy in 2b(ii). It is admitted that that is not an accurate figure and as it stands, that particular head, 2b, cannot, in my submission, be found proved.

Can I turn to 2c and deal first of all with the issue of irresponsible monitoring in the context of heads of charge paragraphs (ii) and (iii) and also I think connected to that (v). Really they are allegations of not making an adequate assessment of the patient’s weight, not monitoring the patient’s growth and not advising the patient’s general practitioner to monitor Patient A as above.

I take (v) as drafted to be a reference to the monitoring requirements and failures alleged in (ii) and (iii) in relation to weight and growth.

In relation to those heads, the background is set out again in the letter, the first letter that he wrote at page 72. Again, I do not ask you to look it up. It is 3 May 1996. It is clear from the letter that he was alert to the decline in the patient’s appetite and the knock-on effect that might have on the patient’s weight. Talking about the use of Ritalin and, of course, we remember that this patient already was being prescribed Ritalin by Dr Vereker:

“It does tend to cause a fall in appetite and A is already at about 75% of his pre-Ritalin level. I will monitor his progress and have asked his mother to have him weighed so that we can see the
course of his weight.”

It is clear also from that letter that Dr Cosgrove was either misinformed as to his current weight or miscalculated the weight that was given to him in assessing the relevant centile the patient was on. That misapprehension on his part was, in the context of the patient care, rapidly corrected within weeks by the receipt of Dr Holme’s letter of 22 May where Dr Cosgrove was made aware that this patient’s weight was in fact not on the fiftieth centile but was between the second and ninth centile. That is page 93 of C12. That is the background.

The allegation is that he did not make an adequate assessment of the patient’s weight and did not monitor the patient’s growth, which I take to include both weight and height. It is admitted for the purposes of this particular patient that there is no evidence before you that Dr Cosgrove himself weighed or measured the height of patient A and, indeed, if one reads his letters the indication is to the contrary – that he did not. That failure personally to measure, in my submission, does not make for irresponsible monitoring because Professor Taylor has accepted in giving evidence before you that it is quite appropriate to delegate that function to a relevant clinician, usually to a general practitioner.

That delegation, in my submission, does not have to be formally set out in a written protocol signed by both parties, ideal though that might be. The significant factor is to establish whether or not such a delegation took place and was effective. In my submission, it is clear from what happened that Dr Cosgrove could be satisfied that such a delegation of monitoring of height and growth had taken place and was effectively being done.

I say that and I make that submission because Dr Cosgrove received correspondence from Dr Holme in these circumstances, and that is the letter of 22 May from Dr Holme. The circumstances are these, first that Dr Holme had received Dr Cosgrove’s letter expressing a desire to have the patient’s weight monitored because of the concern about loss of appetite.

Secondly, Dr Cosgrove knows that at that consultation on (I think it was) 19 May – it may have been 16 May – that not only was Dr Holme present, the paediatrician, but also Dr Vereker, the other treating psychiatrist, was present for a large part of that consultation. Therefore, that the paediatrician had a psychiatric input into that consultation. Both of them knew about the Ritalin context and what had been recommended by way of prescription by Dr Cosgrove in terms of dosages.

Thirdly, Dr Cosgrove would have known that Dr Holm had measured the patient’s height and weight because he was told so in the letter – they were both between the seventh and ninth centiles.

Fourthly, that Dr Holme had – and it is perhaps important that I quote him on this – in his letter to Dr Cosgrove said:

“I have offered to keep an eye on A’s overall growth and development and I will see him again in six months.”
I would submit on the basis of that knowledge that Dr Cosgrove had at the time that he was entitled to conclude that Dr Holm had at the least agreed to share responsibility for monitoring the growth (weight and height) of the patient and, for what it is worth – and it is not at this stage – blood pressure.

It was, in my submission, ingenuous of Dr Holm in evidence before you to dispute that he was taking or had agreed to take any responsibility for monitoring the patient’s height, weight and blood pressure. I say that that lack of disingenuous approach of Dr Holm is borne out if you look at what he was writing at the time and during the course of the subsequent consultations, because in all of those subsequent consultations blood pressure was taken and it was taken not in the general review of health (although that may well have been done) but in the specific context of the problem of ADHD. You will see, if you look at all the clinic letters that follow those clinic appointments, they are headed “ADHD Problem” or “Hyperkinetic Problem” and copied to Dr Cosgrove.

So that was the arrangement in place and the reasonable understanding that Dr Cosgrove was about to attach to those arrangements, about which he knew and about which he was kept informed.

He also, of course, was himself monitoring the patient by telephone in conference with the mother, and he writes again in July – again at C12, at 68 to 69 (I do not ask you to look it up) – where, in the light of specific concerns from the mother, it is clear that he is not merely relying on Dr Holme’s six monthly checks in relation to weight, it is clear that he is seeking further assistance from the mother in terms of weight:

“He is growing in height and his weight is satisfactory.”

We also have, of course, Dr Holme’s comment in one of his letters on page 86 at C12, that Dr Cosgrove kindly checks his progress by telephone every two months or so.

That is the factual background. Those are the reasons why, I submit, it cannot be established on the evidence that there was here an inadequate assessment of the patient’s weight or an irresponsible monitoring of the patient’s growth as alleged in (ii) and (iii).

In relation to the relation (v):

“you did not advise Patient A’s General Practitioner to monitor Patient A as above”,

as a fact that is not disputed but in the context that it is put in as an element or an item of irresponsible monitoring, it is, because of the monitoring arrangements that had been established not in this case with the GP but with the paediatrician.

I turn to (i), which is on a different topic really, the allegation of a failure to see the patient in person between May 1996 and May 1999, that fact amounting to an item of irresponsible monitoring. Again, it is conceded that he did not in fact see the patient between those dates – the evidence clearly points that way and is not contested by Dr Cosgrove.
Does it amount to irresponsible monitoring? The allegation arises, in my submission, in this context, that because here we have a patient (a) who was on a high dose of Ritalin, over and above 60mgs, and (b) who was on other medication, namely Risperidone and Clonidine, there was a need for personal assessment by the treating psychiatrist because of the risk of such factors as hallucination, depression, perseveration of attention. You, of course, are not bound by Professor Taylor’s views on the desirability of personal assessment in those circumstances and in the light of those risks, and you are entitled to consider the whole body of expert evidence, whether it be in the form of oral evidence from Professor Taylor or other literature that has been put before you and cited to you.

I just say this in relation to the particular risks. In relation to hallucination, Dr Cosgrove says at paragraph 13.9 of his enclosure J, which is his response to an original letter from Professor Taylor, he cites there what the manufacturers of Ritalin, Novartis, say about the risks of hallucination from the administration of that drug, namely that they are less an 0.1 per cent or less than one in 10,000, and that the risk – and this is something not coming from the manufacturers but from Dr Cosgrove himself – is further reduced in the context of his treatment of this patient because with the addition of Risperidone, an antipsychotic, he suggests that the risk of hallucination is further reduced.

Perseveration of attention: not mentioned as a significant side effect in either the practice parameters document or the document which we have at C10 page 331 under their “Side Effects” heading. If it does not make it into those documents presumably it was safe for Dr Cosgrove to disregard that as a possible or significant risk in this case.

Depression: it was said by Professor Taylor that that is something that really only a psychiatrist could properly anticipate; it is something that a paediatrician might not be able to detect. Again, you are not bound by that assertion by the professor and, of course, you can bring your own knowledge to bear on that. But it would seem, in my submission, strange that a paediatrician, alert to the medication that this patient is on, might not be able to detect clinical signs of depression when seeing patients – which is certainly something that a general practitioner might be expected to detect when seeing patients.

So for those reasons I make the submission that the fact that the he did not see the patient during those three years from the first appointment in May 1996 is not an indexed item of irresponsible monitoring.

Item c(iv):

“you did not warn Patient A’s mother that sudden withdrawal of Clonidine could have a deleterious effect on Patient A’s blood pressure.”

Again, as a matter of fact, I do not dispute that Dr Cosgrove did not so warn, and it is clear from the tenor of his witness statement that that was the case, his view, that it was not necessary to warn.

That that was not irresponsible. He sets out in some length his reasoning for that in his witness statement. I will get the reference correct. It is enclosure I, paragraphs 7.12, 7.13 and 7.14. The concern that Professor Taylor had expressed in relation to the
prescription of Clonidine and the use of Clonidine is the possibility of rebound in relation to blood pressure. Dr Cosgrove makes the point in 7.12 that clearly, if you are treating a hypertensive with high blood pressure and the treatment reduces the blood pressure to normal levels, there is a risk on sudden removal of the hypertension recurring.

What he submits is that, in using Clonidine in the treatment of ADHD, you are not treating a hypertensive, but you are treating a person with normal blood pressure and therefore there is no risk of triggering hypertension by a sudden discontinuing of the medication. In any event, he goes on to say at 7.13 that the dose he was prescribing, 0.1 mg per day is such that dose withdrawal effectively takes place every day, because of the life of that particular drug. He cites a mean plasma life of 13 hours with a range of 10 to 20 hours, which means that a once a day dose is being withdrawn from the body every day. Finally, at 7.14, that if there is still any remaining doubt, the recommendation for withdrawing a patient from the dose is to reduce the amount by 0.1 mg per day. That in fact was the dose that was being administered in that particular case.

Again, for those reasons, I submit, it is not an index of irresponsible monitoring in failing to warn the patient's mother about Clonidine and that particular problem.

Patient B. This is solely concerned with the significance of the comments that he makes in the letter of 3 December 1999, which is in C8 at divider 3. My learned friend is right when he says that there is a grammatical point being made here in relation to © (ii) and (iii) of head of charge 3. In my submission, what the doctor was doing here in that letter was, first of all, reporting what he had been told as fact by the patient, that the doctor whom he had seen had been rude and unhelpful and had been scruffily dressed. Whether or not that was adopted later on does not undermine the grammatical point I make that he was not himself directly asserting in the letter – he could not – that Dr Al-Shabner was rude and unhelpful and was scruffily dressed. It was an accurate report of what he was told by the patient. That is established by the patient’s own statement, which one finds at enclosure H to the doctor’s statement. From that report by the patient, and on the assumption that it was correct, Dr Cosgrove has drawn the inferences that are set out in (iv) (v) and (vi) in head of charge 3©.

Those inferences are, in my submission, on the assumption that what he has been told is correct, are reasonable inferences to draw, namely that he knew nothing about ADHD, that he was guilty of medical negligence and the doctor who the patient had seen had demonstrated professional incompetence. That is on the basis of what he was told in the letter on page 3.

"Anyhow this specialist declares, I was told, there is nothing I can do for you."

Indeed, this fits with Dr Al-Shabner telling you that he had left the diagnosis open to the patient.

"I find this a truly amazing statement. Surely it is the doctor/specialist who makes the diagnosis, that it is not something to be left up to the patient. This doctor says that he did inform the patient he may or may not have deficit syndrome, as he calls it, and I somehow let him at least start thinking of why it is that important to
him at this moment in time. It is clear from Dr Al-Shabner’s total misuse of the words “deficit syndrome” that he knows nothing about ADHD. In view of this appalling failure of knowledge about ADHD and in view of Dr Al-Shabner’s failure to elicit the simply dreadful level of the patient’s motivation, in view of his rudeness as reported by the patient, in view of the statement, ‘There is nothing I can do for you’ when ADHD responds so well to Ritalin and Dexamphetamine, I must formally register my strong disapproval of the medical negligence of this doctor.”

Those inferences that he draws from what he was told by the patient are, in my submission, reasonable ones to draw. They may be bold, but they are reasonable on the basis of what he was told. Therefore, those criticisms are not unfounded or unsustainable, which is the allegation he faces here at (d)(ii).

I think it may help if we look at the origin of that word and where it may well have been drawn from by whoever drafted this head of charge. It would appear to come from the 1998 edition of “Good Medical Practice”, which I think you will find at tab 3, where at paragraph 29 under “Working with Colleagues”, the practitioner is told,

“You must not make any patient doubt a colleague’s knowledge and skills by making unnecessary or unsustainable comments about them.”

That translates in coming up to date in the 2001 edition at tab 4, which I think was the passage we had problems with on the pagination, paragraph 35,

“You must not undermine patients’ trust, the care or treatment they receive or in the judgement of those treating them by making malicious or unfounded criticisms of colleagues.”

These criticisms, in my submission, were not unfounded and unsustainable, inasmuch as they were based on the honest, genuine recollection of the patient. As to the meaning of the word “unsustainable”, and I would submit there does not really appear to be any significant difference between that word and the word “unfounded” which is to be found in the more recent edition of “Good Medical Practice”.

It is also suggested that those comments were unprofessional. If they were sustainable comments based on a reasonable foundation, which in my submission they were, namely the patient’s own honest recollection of what he was told, then he is acting unprofessionally in communicating those comments to the patient’s GP, to the patient himself, who after all is the author of the facts on which those comments are based, and indeed Dr Al-Shabner himself.

My reasoning for making that submission is to be found elsewhere in “Good Medical Practice” under the heading “Your Duty to Protect all Patients.” If we look at the 1998 edition, paragraph 23 at tab 3 says,

“You must protect patients when you believe that a doctor’s or other colleague’s health, conduct or performance…
obviously “performance” is the relevant word here,

“is a threat to them.”

At paragraph 24,

“Before taking action you should do your best to find out the facts. Then, if necessary, you must follow your employer’s procedures or tell an appropriate person from the employing authority, such as the Director of Public Health, Medical Director, Nursing Director or Chief Executive or an officer of your Local Medical Committee or a regulatory body. Your comments about colleagues must be honest. If you are not sure what to do ask an experienced colleague or contact the General Medical Council. The safety of patients must come first at all times.”

It is perhaps helpful to look at how that translates in the more recent edition of 2001, tab 4, under the heading “Dealing with Problems in Professional Practice. Conduct or Performance of Colleagues.” At paragraph 26,

“You must protect patients from risk of harm posed by another doctor’s conduct, performance or health…”

Again, “performance” is the relevant word,

“…including problems arising from…”

I do not need to deal with that.

“The safety of patients must come first at all times. Where there are serious concerns about a colleague’s performance it is essential that steps are taken without delay to investigate the concerns, to establish whether they are well founded and to protect patients.”

What Dr Cosgrove was doing, in my submission, was no more and no less than was required of him or advised to him in “Good Medical Practice” in relation to dealing with a perceived problem in the performance of a colleague. It was not necessary in deciding, where he is advised in the earlier edition, to do your best to find out the facts, for him to go further than to establish that the account he had been given by the patient was a bona fide, genuinely held, honestly believed statement of fact by the patient.

It is not for him to investigate and come to a settled conclusion as to whether or not what the patient is saying is correct. In any event, he notified Dr Al-Shabner of what the patient was saying.

That this was the motivation behind what the doctor was doing is set out in his witness statement at paragraph 40.8. I do not take you to it, but it makes clear in that paragraph that he was saying, “What is one to do? One is entitled to take steps to seek to protect the patient.”

Those paragraphs in the 1998 edition of “Good Medical Practice”, paragraphs 23 and 24
and the paragraphs in the later edition at 26 dealing with conduct and performance of colleagues, and particularly paragraph 26 in the later edition, make it clear that the doctor does not have to conduct his own personal investigation into establishing whether or not the facts are well founded. He has to take steps to put in train a process. It does not have to be conducted by him. It may be conducted by others to establish whether they are well-founded.

I say that and I draw support, I hope, from this analogy. Suppose a female patient goes to see a consultant gynaecologist and tells that consultant, “Doctor, I saw the other day one of your colleagues, another consultant gynaecologist and in conducting a breast examination of me, he so manipulated my breasts in a way that was not consistent with a proper examination of the breasts” and she describes a touching, for example, a fondling of the breast, which is wholly inconsistent with a proper breast examination.

That consultant considers that, if that account is correct, she is describing an indecent assault, a criminal offence. He or she then decides to report what the patient has told him to the patient’s GP in a letter, copying that letter to the patient and, indeed, to his colleague, the consultant gynaecologist. Can he be criticised for so doing? In my submission, not.

He is not obliged beyond establishing that the patient has given him a bona fide account to conduct his own investigation into whether or not those facts are true or false, correct or incorrect. That is clearly a matter for others to take forward. The step he takes is to report it to the general practitioner.

Is he the subject of criticism for not going, as it suggested he should do, to the relevant clinician’s own employers, the medical director, etc? Not, in my submission, a failing on the doctor’s behalf, on the doctor’s part and, indeed, to his colleague, the consultant gynaecologist. Can he be criticised for so doing? In my submission, not.

If I can summarise my submissions in relation to Patient B, (a) he receives an account, a factual account, which he reports accurately in his letter to the general practitioner. He is satisfied that the account is genuine, honestly held and believed by the patient. He draws a reasonable inference from that that what he has been told is a description of incompetence and negligence on the part of his colleague clinician and writes such in his letter.

That is a proper foundation for writing such a comment and it is not unprofessional to report those facts and his inferences drawn from those facts to the general practitioner, the patient’s general practitioner, with a copy to the patient and the person who he criticises on the basis of reported facts.

Patient C falls into two parts; the first, monitoring in relation to head of charge 4 and,
second, the nature of the complaint made by Dr Cosgrove in the letter of 7 July 1999, head of charge 5, concerning Dr Moses.

First of all, the question of monitoring and advice. The letter of 29 May sets out the recommendations as to the prescription of Risperidone and Ritalin. It did not contain any advice to the GP about the appropriate monitoring of the patient while he was taking those drugs and it is suggested that that failure was irresponsible and not in the best interests of the patient. So, it is an allegation really that boils down to a failure to advise the patient’s GP about appropriate monitoring of the patient on that medication.

What happened here was just as with patient A. In the letter to the general practitioner, Dr Rackham, in his final paragraph he sets out:

“I have made out a private prescription for Ritalin and Risperidone but I know that his parents would very much appreciate it if you would copy it down on to an NHS scrip. On each occasion that I alter the dosage I will send them a fresh private prescription to bring to you. You may care to keep them in his file.”

Again, that triggers an obligation on the part of the general practitioner to exercise his or her own independent judgment before agreeing to transcribe those prescriptions and issue NHS prescriptions to the patient’s parents, or the patient’s mother.

That independent judgment, the doctor, Dr Cosgrove, is entitled to consider, would be exercised as, indeed, it was, in my submission, because you have the uncontradicted evidence from the patient’s mother, Mrs C, that Dr Rackham did, indeed, check the patient’s height, weight and blood pressure on a regular basis, namely every eight to twelve weeks, a regime which Professor Taylor accepted in evidence would have been an acceptable monitoring regime.

It is for that reason, in my submission, that it cannot be said that the failure to set out that advice, namely the need to monitor blood pressure, height and weight, was irresponsible and not in the best interests of the patient, because he was entitled to assume an exercise of independent judgment by the GP in the light of the proposed prescription of this particular medication. If the doctor had any concerns about what he was to do, he was there and available, ready to answer those concerns.

May I suggest an analogy from another field, though still within the psychiatric field. A Community Drugs Team sees a patient who is a heroin addict, assesses the patient and feels that it is appropriate that that patient is prescribed methadone in order to treat the heroin abuse. Because of budgetary constraints, the CDT is not able to prescribe itself the methadone and writes a letter to the patient’s general practitioner recommending a prescription of an appropriate amount of methadone to the patient.

That CDT, in my submission, is not obliged to say in the letter, “Before you do so you ought to examine the patient and take urine samples from the patient to ensure that the patient is opiate positive.” Those are matters, in my submission, that the CDT can properly leave unsaid, relying on the independent judgment that has to be exercised by all general practitioners when they come to prescribe. When they prescribe drugs they are
expected to know the effects of drugs, how they need to be monitored following prescription and, if they do not, they must raise it with the specialist who is inviting them to make that prescription.

Of course, here we know that Dr Cosgrove had the additional clinical luxury that from time to time Mrs C brought her son to see him in person for face-to-face consultations, where he could reassure himself that the monitoring that the GP should have been doing and was doing in this case was, in fact, in place.

Patient C, I move on to head of charge 5, which is the letter that was written by Dr Cosgrove on 7 July 1999.

Again, the same scenario, in my submission, exists here as did for Patient B. Dr Cosgrove was reporting accurately the patient’s medical history as given to him by the patient’s mother. My learned friend was good enough to accept, concede, that Mrs C was doing her best to be accurate before you and was not a dissembling or dishonest witness. So, that is the first plank, in my submission.

The second, it was a reasonable inference to draw from that history to say that more should have been done for the patient and, in particular, that it would have been proper actively to consider medication as something that had not, on Mrs C’s account, been done. That is an inference with which Professor Taylor agreed when that scenario was put to him in evidence, that it would be a proper inference to come to that conclusion that more could be done for this patient.

That was the inference that Dr Cosgrove drew and set out not explicitly, perhaps, but inferentially in the letter when reporting what he was told by the patient’s mother.

That is the second plank. Because it is a reasonable inference based on bona fide given information, it was a sustainable comment to make and it was not unprofessional to report that comment to the patient’s GP, the patient’s parents and to Dr Moses herself, the subject of the critical comment.

Patient D. The allegation here is in relation to the consultation on 21 May 1996. It deals with, at 6d, the allegation is that:

“The examination on that occasion was inadequate in that you did not weigh him, you did not take his blood pressure.”

I accept that the evidence is all one way on that in relation to the fact that he was not weighed by Dr Cosgrove himself and did not have his blood pressure taken either by Dr Cosgrove. I make that concession, albeit in the light of other evidence from other patients, the parents have given evidence before you, where the suggestion is that that was done in their cases. In this case the evidence would point in that direction.

The issue, then, is whether or not the failure to weigh, the failure to take blood pressure on that initial occasion, was an inadequate examination of the patient.

Again, I submit this. Dr Cosgrove knew that in making the recommendation for
A

prescription that he did in his letter in the same terms as the earlier letters that I have already taken you to, that would trigger the general practitioner’s need to exercise his or her independent judgment. Indeed, it did trigger an exercise in judgment, as we know. The GP - I think it was Dr Taylor at that time, before the transfer to Dr Spence – took the view that she should not prescribe Ritalin and went to consult the consultant psychiatrist who had given a second opinion in relation to this child at the request of the mother, Dr Barton, a child psychiatrist well known to Professor Taylor. Dr Barton referred the issue over to the hitherto treating psychiatrist, Dr Robinson and, as a result of consulting Dr Robinson, got approval to prescribe from Dr Robinson that which Dr Cosgrove was recommending should be prescribed and a monitoring regime was put in place, as we see from the notes that are set out in the chronology I have put before you.

B

Again, in my submission, Dr Cosgrove was entitled to consider that the appropriate monitoring relevant to that drug and its use in the treatment of ADHD would be put in place following reference of the prescription of the general practitioner. Dr Cosgrove would be able to secure reassurance on that issue of physical monitoring during the telephone consultations he would have with the patient’s mother when he titrated the doses according to the feedback that he was getting from the mother in relation to the effects of the medication on the child’s behaviour, both at home and at school.

C

I do, however, have to make one concession in relation to the allegation of a failure to make proper arrangements for monitoring the effects of treatment which he provided for the patient, and that is this. It is clear from the monitoring regime that was put in place that it omitted the monitoring of blood pressure. Height and weight were to be monitored on a three-monthly basis and there does not appear to be any evidence from the clinical records that blood pressure was also monitored. It is accepted that that would be part of the appropriate regime. I would have to concede on Dr Cosgrove’s behalf that that is something he should have picked up during the course of the telephone conversation and take action upon, and there is no evidence that he did so. So to that limited extent I would concede that there had been a failure under head of charge 6f.

D

Patient E, and there are two elements to this: head of charge 7 is the failure to supply notes; head of charge 8 the comments in the letter of 3 October 2000. My submission in relation to the allegation of impropriety and unprofessional behaviour in relation to the failure to supply notes is that in refusing Miss Samways’ request Dr Cosgrove was acting with the consent and authority of the patient’s mother, Mrs E. The patient’s mother was questioned by your Chairman specifically about her state of mind and the background to the refusal by Dr Cosgrove to disclose the notes and she told you that it was a shared decision not to disclose the notes. The issue about not disclosing the notes was, she felt, probably raised by her during the course of a routine telephone consultation at which Dr Cosgrove would have telephoned her for the purpose of monitoring the child.

E

She had not made a written reversal of her previous written consent to disclose the notes because she took the view that the doctor’s letter would effectively deal with that issue. My learned friend says that there is a significant passage in a letter she wrote to the General Medical Council and the use of the word “now”, suggesting that it was something that with hindsight she was prepared to ratify the refusal. That is not borne out by the evidence that was given by the patient’s mother before you, nor is it borne out, in my submission, by another letter which she wrote which you have at enclosure Q to the
A

witness statement – and I will read you the relevant passages:

“I am writing out of complete support for you.”

So it is clear it is a sort of testimonial letter in support.

B

“I am amazed about the allegations against you, on behalf of treating my son. I am in full and total backing of yourself on this matter.

I find that Wendy Samways handling of this matter to be rude and offensive, she wrote that I would be concerned about your refusal to send copies of the notes that you hold, which was offensive and I felt and I still feel you acted out of E’s best interest.”

C

She then goes on to describe how E came to him as an unhappy, mixed up, crazy child. She goes on to say this:

“The NHS Trust did not pick up the fact that E also was suffering from Tourettes, which is a feat in itself.

As I was in dispute with the Trust over E’s care, I do feel your actions helped us to come to a quicker resolution without any inappropriate questioning of the care you were giving E, which I feel would have happened, which in turn would have dragged out our complaint with the Trust, and so I can only give you many thanks for preventing this from happening.

I think that the GMC should bear more mind to medical neglect than to question consultants manners, especially when parents of patients give full permission to act in any particular way, ie refusal to send copies of notes!!”

So she is there making quite clear her authority – prior authority, in my submission, of Dr Cosgrove’s refusal to forward the notes.

D

The letter he writes, the subject of head of charge 8, 3 October 2000: all the factual matters that appear in the letter are admitted. Again, the comments that he makes in that letter about inadequate care – and if I can deal with that head first, separately from the others at (ii), (iii) and (iv). At (i):

G

“that Patient E had been inadequate care by an employee of the Oxfordshire Mental Healthcare NHS Trust.”

Again, in my submission, based on reports from the parents, accurately reported by the doctor. It was reasonable, I submit, to criticise the refusal to prescribe Risperidone – which was the nub of his allegation of inadequate care. I say that because the fact is that the doctor himself prescribed Risperidone and no criticism is made of him for so doing. It was reasonable to report that comment of inadequate care to the manager of complaints at the Trust in accordance with the arguments I have set out before on
previous occasions based on what a doctor should do as set out in Good Medical Practice. So sustainable comment; it was not unprofessional to report to the complaints manager.

In relation to the comments at (ii), (iii) and (iv) about the nature of the investigation that was going to be carried out, those comments echoed, if the evidence of Mrs E is correct, views that had already been expressed by the Community Health Council from whom Mrs E sought advice and assistance in the prosecution of her complaint, and it also accorded with the view which was already held by the parents as a result of their discussion with the Community Health Council representative. So his comments about whitewashing and inadequacy of the investigation as set out in (ii), (iii) and (iv) were based on and echoed comments already made by the CHC and the parents themselves. They were again, therefore, in my submission, sustainable comments and it was not unprofessional to report those comments to the complaints manager of the Trust – who, after all, was setting up the inquiry about which criticism was made.

Patient F---

THE CHAIRMAN: I am sorry to interrupt you, Mr Morris. I wonder if I might suggest that this could be an appropriate point to have a break? I understand that the Legal Assessor’s advice will last about 15 minutes, so we are going to have to come back after lunch anyway, and it might be as well to have a break just now. You could complete your submission and we could then get the advice of the Legal Assessor.

MR MORRIS: Yes.

THE CHAIRMAN: So we will recommence at ten-to two.

(The Committee adjourned for lunch)

MR MORRIS: Patient F, head of charge 9: the allegation here relates to the comments made in the letter written by the doctor on 17 November 2000 in divider 9. Again, I make the same submission I have made in respect of previous commentaries by the doctor. The doctor was reporting accurately what the patient had told him, and on the basis of that report the doctor drew some inferences which he set out in that letter. What he had been told is that the doctor, it had been felt, had not listened to the patient when he was talking about his personal understanding of the ADHD condition; that the doctor had told him that ADHD was a concentration problem and it was for messy kids – in other words, it was not relevant in an adult context – and from that he drew the inference that that was an ignorant comment and that both Dr Thomas and her supervising consultant were arguably guilty of medical negligence in relation to that. In relation to the allegation also in the report that the consultant reported back to Dr Thomas, who in turn reported to the patient, “The consultant thinks you have got a personality disorder which is not treatable”: the comment about that was that that was therapeutic and negligent.

Finally at (vi), a comment about medical negligence, if it was being asserted that there had been negligence if the patient responded to treatment that had been given by Dr Cosgrove and that the failure to listen to the patient and in not knowing what ADHD was – that it was not a real condition in adults – led to the complaint.
You will have heard what Professor Taylor’s view was about the comment that ADHD is a concentration problem and that it is for messy kids. He took the view that, if said, that was both unprofessional and unacceptable, and he expressed the view that psychiatrists would not usually say that you have got a personality disorder and it is untreatable, and therefore inferentially it criticised that comment, if it were made.

So again, in my submission, they were reasonably founded comments, therefore sustainable, and not unprofessional to report those comments in the letter to the general practitioner with a copy to Drs Thomas and Chubb.

Patient G: the criticism there relates to the irresponsible monitoring in not making an adequate assessment of patient G’s weight, not monitoring patient G’s growth and not adequately monitoring any possible side effects. In my submission, the Council has an evidential problem here. There is, in my submission, no evidence of an absence of physical monitoring by the general practitioner and, again, I would say that delegation would be appropriate to the practitioner.

The prescription was a recommendation to the General Practitioner. There is therefore the automatic conclusion that the General Practitioner was obliged to exercise his or her independent judgment. There is no evidence that that judgment was not so exercised, whether by evidence from the General Practitioner or evidence from the clinical notes. Indeed, if one looks at the letter of 27 May of divider 10, page 9, from Dr Hales to Dr Judge, the GP is there saying,

“His height recorded in the clinic today was 108 cm. His weight was 16 kilograms. His mother says that his weight has dropped a kilogram since starting the medication.”

It suggests, in my submission, that there was a monitoring regime in place in relation to this child.

Finally, if I can come to Patient H, again it is a commentary case surrounding the letter of 19 July 2003. It is the same framework to my submissions. There is no evidence but that the facts related to the doctor were accurately recorded in the letter, that the facts as related were honestly recollected by the patient. Those were these: Dr Cosgrove says,

“I understand that H was seen by Dr Dover about a year ago for one appointment. I was told by Mr and Mrs H that Dr Dover told them that he did not believe in ADHD and that it was too Americanised. I was informed that Dr Dover told H’s parents to go away and to sort out their own lives. I was also told that Dr Dover did not read H’s school reports, not did he ask to see them. According to H’s parents, his head teacher was concerned at what Dr Dover had told the parents to do, namely to go away and to sort out your own lives.”

Again, on the basis of that account, honestly given by the patient’s parents to the doctor, he was being told about a clinician who did not believe in the concept of ADHD and, on the basis of that, it was a perfectly reasonable comment to make that if that were the case he might be in trouble with re-validation by the General Medical Council.
The comment again in relation to the failure to study school reports is reasonable in my submission, based on the parameters we have been told about, the guidelines and the protocols suggested by Professor Taylor and that he had not behaved professionally in not arranging a second opinion when asked to do so. Again, it is a perfectly reasonable comment to make. Again, therefore, it is a sustainable commentary and not unprofessional in being reported to the patient’s General Practitioner with a copy to Dr Dover.

THE CHAIRMAN: I am sorry to interrupt, Mr Morris. Did I miss out any reference to 10©? My recollection is that 10©(i) and (ii) were not admitted at the outset of the hearing.

MR MORRIS: Sir, I think that was right.

THE CHAIRMAN: My recollection was that it appeared to be admitted in the first round, but then the admission of 10©(i) and (ii) was withdrawn.

MR MORRIS: Sir, yes. I think in the light of the evidence I am not in a position to make any submission that that is not the case. Sir, those are my submissions.

THE CHAIRMAN: Thank you very much. I now turn to the Legal Assessor.

THE LEGAL ASSESSOR: I have prepared a written advice, which I propose to read into the record. The point has now been reached when the Committee has to decide which, if any, of the unadmitted facts in the heads of charge they find proved. Then the Committee has to decide whether or not those facts so proved, if any, taken with the admitted facts are insufficient to support a finding of serious professional misconduct or, put another way, whether those facts are capable of constituting serious professional misconduct.

Taking the factual task first, I am required to remind you that the burden of proving these facts rests on the General Medical Council and the standard to which you must find each of them individually proved is beyond reasonable doubt so that you are sure of each of them individually. There is a danger that this familiar advice becomes with repetition simply an incantation. It is a living practical principle of justice and my advice is that you should keep it to the forefront of your minds at all times when evaluating the evidence.

Turning to the second task, you have to be satisfied that the admitted facts and those found proved, if any, are capable of amounting to serious professional misconduct. In deciding whether or not this is the case, my advice is that if you are left in any doubt as to whether they are so capable - and I stress that word “capable” – of constituting serious professional misconduct, the benefit of any doubt should be given to Dr Cosgrove.

What is serious professional misconduct? It is conduct which has a link with the practice of medicine and which, in the circumstances of the case, represents serious breach, whether by omission or commission, of the rules and standards, written and unwritten, ordinarily required to be followed by the registered medical practitioner. It does not require moral turpitude. As this case involves allegations concerning the medical
performance of Dr Cosgrove, e.g. his failure to monitor, I should add that gross professional negligence may fall within the ambit of serious professional misconduct. But, it has to be something far more than that which simply gives rise to a civil liability for negligence. The negligence has to be something that truly calls for the opprobrium that inevitably attaches to a disciplinary charge for that type of conduct to be serious professional misconduct.

That is the general advice I wish to give, but there remain a number of specific points that I need to briefly refer to.

Firstly, Dr Cosgrove has not given evidence in person before you. No inference and certainly no adverse inference should be drawn as to why he has chosen not to do so. Dr Cosgrove is entitled to have the case decided solely on the evidence before the Committee which, of course, includes the evidence called in his defence. An allegation has been made against him and he is entitled to require the General Medical Council to prove it and to prove it beyond reasonable doubt in the face of the evidence that he has chosen to present.

Secondly, some of the evidence before you is in the form of unadmitted written statements, i.e. the contents are not admitted by the other side. Pre-eminently this includes the statement of Dr Cosgrove himself and the exhibits attached to that statement. For the General Medical Council the statements of Dr Chubb and Dr Dover are in this form. These constitute evidence before you and may be properly used in making findings of fact, whether positive or negative, either favourable or adverse to Dr Cosgrove.

However, my advice is that, in considering how probative the evidence is, i.e. its weight, you should, before making any findings of fact on the basis of that evidence, caution yourselves that the makers of those statements have not been subjected to cross-examination and, consequently, the evidence is not as weighty as evidence you find compelling and credible after cross-examination. That mental note of caution made, i.e. if you remind yourself of the absence of cross-examination, the weight that you place on those statements thereafter is entirely a matter for you.

Thirdly, half of the charges relate to letters written by Dr Cosgrove to other medical practitioners. It is a characteristic of those charges that the contents are said to be both unprofessional and unsustainable. In relation to the allegation of them being unprofessional, I advise that, in deciding whether they are proved beyond reasonable doubt, the professional standards to be applied are those prevailing at the time the letters were written. Regard may properly be had to the “Good Medical Practice” publication current at that date.

In deciding whether the contents of the letters are proved beyond reasonable doubt to be unsustainable, and I note here that the General Medical Council by the use of that word allege that the contents are not capable of being sustained, which is, you may feel, more emphatic than alleging that they are simply not correct.

I advise that you are required to take into account all the evidence, including that of the defence witnesses and the statement of Dr Cosgrove. Once considered, the weight attached to a particular piece of evidence is then a matter for you.
Fourthly, the remainder of the charges include those that relate to the monitoring by Dr Cosgrove and the effect of the drugs prescribed by him. They include allegations of irresponsibility, that his examination was inadequate and that a failure to forward medical notes was, inter alia, inappropriate and failure to advise monitoring of a patient’s prescribed drugs was irresponsible and not in the best interests of the patient.

Taking these allegations as being allegations against the actual medical performance of Dr Cosgrove, my advice is that in deciding whether or not these allegations are proved beyond reasonable doubt, regard should be had to the medical standards and knowledge prevailing at the time of the alleged default and not that which is known today at the date of the hearing.

Fifthly, you should consider each head of allegation separately. Each head should only be found proved if you are satisfied such that you are sure of it. This vital principle may be illustrated by a specific point which I wish to make about charge 2. Each allegation in 2(b)(i) to (vi) should be so considered separately and to the requisite standard of proof. So should each allegation in 2(c)(i) to (v). When that is done, as a separate exercise, you should consider if the facts in 2(c)(i) to 2(c)(v) that are found proved themselves prove beyond reasonable doubt that the allegation made in the opening sentence of 2(c), i.e. irresponsible monitoring, is so proved beyond reasonable doubt. In this way the cardinal principle of the General Medical Council having the burden of proving each allegation to the point where you are sure is given practical effect.

Lastly, my role is to advise you on the law. You are not obliged to follow my advice. However, should you wish not to follow it, I advise you to state in your determination the reasons why you decline to do so and to state what you consider to be the appropriate law. Let me make it quite clear that this is not out of some kind of injured professional pride, but for the infinitely more important reason that Dr Cosgrove, and for that matter any reviewing Court, will then know with certainty what law was applied in this case.

That is my advice.

THE CHAIRMAN: I take it there is no dissent from that advice.

MR MORRIS: No, sir.

MR PEARCE: No, sir.

THE CHAIRMAN: At this point we will now go into camera.

Mr Morris, the Committee have given detailed consideration to all the evidence adduced in this case, and have taken account of the submissions made by Counsel and the advice given by the Legal Assessor. They have borne in mind that the burden of proof rests on the GMC and that the standard of proof required is that they should be sure, beyond
reasonable doubt. The Committee have considered each head and sub-head of charge separately. Accordingly, they have made the following findings on the facts:

Head 1 has been admitted and found proved.

Head 2(a) has been admitted and found proved
Head 2(b)(i) has been found proved
Heads 2(b) (ii) and (iii) have been found not proved
Heads 2(b)(iv) and (v) and (vi) have been found proved

The Committee considered Heads 2(c)(i) to (v) as factual heads of charge initially and then considered their findings in relation to the stem of that head of charge.

Heads 2(c)(i) and (ii) have been found proved
Head 2(c)(iii) has been found not proved
Heads 2(c)(iv) and (v) have been found proved
Stem of Head 2(c) has been found proved in relation to heads 2(c)(i), (ii), (iv) and (v) only.

Heads 3(a) and (b) have been admitted and found proved
Head 3(c)(i) has been admitted and found proved
Heads 3(c)(ii) and (iii) have been found proved
Heads 3 (c)(iv), (v) and (vi) have been found proved
Heads 3(d)(i) and (ii) have been found proved
Head 3(d)(iii) has been admitted and found proved

Heads 4(a), (b), (c) and (d) have been admitted and found proved
Heads 4(e) (i) and (ii) have been found proved

Head 5(a) has been admitted and found proved
Heads 5(b)(i) has been admitted and found proved
Heads 5(b)(ii) has been found proved
Heads 5(b)(iii), (iv) and (v) have been admitted and found proved
Heads 5(c)(i) and (ii) have been found proved
Head 5(c) (iii) has been admitted and found proved

Heads 6(a), (b) and (c) have been admitted and found proved
Heads 6(d)(i) and (ii) have been found proved
Head 6(e) has been admitted and found proved
Head 6(f) has been found proved.

Heads 7(a), (b) and (c) have been admitted and found proved
Heads 7(d)(i) and (ii) have been found not proved

Heads 8(a) (i), (ii), (iii) and (iv) have been admitted and found proved
Heads 8(b)(i) and (ii) have been found proved
Head 8b(iii) has been admitted and found proved

Heads 9(a) and (b) have been admitted and found proved
Head 9(c)(i) had been admitted and found proved
Head 9(c)(ii) has been found proved
Heads 9(c)(iii), (iv), (v) and (vi) have been admitted and found proved
Heads 9(d)(i) and (ii) have been found proved
Head 9(d)(iii) has been admitted and found proved

Heads 10(a) and (b) have been admitted and found proved
Heads 10(c)(i) and (ii) have been found proved
Heads 10(d)(i) and (ii) have been found proved
Head 10(d)(iii) has been found not proved

Heads 11(a) and (b) have been admitted and found proved
Heads 11(c)(i), (ii) and (iii) have been admitted and found proved
Heads 11(d)(i) and (ii) have been found proved
Head 11(d)(iii) has been admitted and found proved

Having reached findings on the facts the Committee then considered whether the facts found proved would be insufficient to support a finding of serious professional misconduct. The Committee concluded that they would not be insufficient

The procedure now is that the Committee will now invite Mr Pearce to adduce evidence, if he wishes to do so, as to the circumstances leading up to the facts which have been found proved, the extent to which these facts indicate serious professional misconduct on the part of Dr Cosgrove and as to his character and previous history. After that, the Committee will invite Mr Morris to address them on those matters and also to adduce evidence in mitigation, if he wishes to do so.

The Committee will then proceed to consider whether Dr Cosgrove has been guilty of serious professional misconduct in respect of those facts which have been found proved against him and, if so, they will go on to consider their determination as to whether or not they should make any direction regarding his registration.

In the event that the Committee were to find that the doctor is guilty of serious professional misconduct, the Committee would wish both Counsel to make reference to the Indicative Sanctions Guidance when making submissions on sanction, using the criteria as set out in the guidance to draw attention to the issues which appear relevant to this case.

Mr Pearce and Mr Morris, I am conscious of the time of day and I would suggest that we defer any further submissions until tomorrow morning, if that is in agreement with you.

MR PEARCE: I agree, sir. That would certainly suit my convenience.

THE CHAIRMAN: Would nine o’clock be an inappropriate time to start tomorrow?

MR PEARCE: That is fine, sir.

THE CHAIRMAN: Until tomorrow at nine.
The hearing was adjourned until the following day
MR D MORRIS, of Counsel, instructed by Messrs RadcliffesLeBrasseur, appeared on behalf of Dr Cosgrove, who was not present.

MR R PEARCE, of Counsel, instructed by Messrs Field Fisher Waterhouse, appeared on behalf of the Council.
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THE CHAIRMAN:  Good morning. When you are ready, Mr Pearce.

MR PEARCE:  Sir, there are various matters I seek to deal with in submissions at this stage. If I may start with dealing factors relevant to the circumstances of the heads of charge found proved, you have heard the evidence in respect of those. There is one matter I ought to bring to your attention that is relevant when one comes to the issue of the Indicative Sanctions Guidance. That is this: that the initial rule 6 letter in this case was sent out on 1 October 2002. It referred at that stage to patients A to F inclusive and made allegations both in respect of disparagement of colleagues, if I can put it that way, and prescribing and monitoring practices. You will have noted that the final two charges, 10 and 11, relating to patients G and H both relate to matters in the year 2003, that is to say events after the rule 6 letter was sent out referring to the charges in respect of patients A to F inclusive. The relevance of that chronology will be apparent to you if you look at the Indicative Sanction Guidance. I will draw it to your attention when I get to that section of the Indicative Sanctions Guidance. Beyond that I think I can add nothing to what you have heard in evidence in terms of the circumstances of the allegations.

I move on to the question of whether this amounts to serious professional misconduct. It is, on the face of the charges that we allege that it is, it is, I hope, apparent from the way that I have put the case why we allege it amounts to serious professional misconduct. In essence, there is a two-fold point here. The first is that the conduct admitted in some cases and found proved in other cases of this doctor risked putting patient care at risk. There was a possibility that patient care would be put at risk and this was not a good standard of practice and care as can be expected from a doctor.

Sir, we accept that on the evidence you have heard, and I anticipate from documents that will be put in front of you by way of mitigation that you may form the view that this doctor’s practice was patchy, patchy in this sense: that, although you have made findings in respect of aspects of his practice and care that may indicate to you that it is unsatisfactory, you have heard evidence already and you will, I anticipate, hear evidence from my learned friend suggesting that in other case his practice has been good. We acknowledge that this is not a case of us saying that this is all bad practice and an unremittingly bad picture.

The second aspect of the seriousness of the conduct that we indicate is that not only did Dr Cosgrove’s actual conduct put patient care at risk, but also that his conduct, particularly in terms of disparagement, was likely to interfere with the care of patients by other professionals. In respect of that, I refer you again, as I have done in the past, to the comments about working with colleagues in the various editions of ‘Good Medical Practice.’ I referred you to them in opening. They have been referred to in closing submissions and you will be aware of them.

If I may move on from that area to dealing with the question of character and the history relating to Dr Cosgrove, there are no previous findings against this doctor. In terms of history outside the matters you are concerned with here, there is one document I seek to produce to you in the course of these submissions. I have mentioned it to my learned friend and I produce this documentation if I may. (Same handed)

THE CHAIRMAN:  This will be C15.
MR PEARCE: This is correspondence from Dr Cosgrove to the General Medical Council in March of this year. The relevant parts of this letter, dated 16 March of this year, are that Dr Cosgrove indicates that he has retired from medical practice. He encloses a copy of a letter to this effect sent to his patients. He indicates that from 4 February this year he ceased to hold any private practice positions, to make out prescriptions and to sign medical certificates of any sort. From that letter one sees what Dr Cosgrove’s current stance is in respect of medical practice. The attached letter is there for the sake of completeness, no more than that. It indicates that he has had to close the Bristol Priority Clinic because of the need to register with the now replaced National Care Standards Commission.

May I finally turn to the Indicative Sanctions Guidance.

THE CHAIRMAN: Before you do so, Mr Pearce, could I check the situation in the light of this letter of 16 March 2004 from Dr Cosgrove? He talks about not paying his annual subscription so that his name would not be maintained on the Medical Register.

MR PEARCE: Yes. My understanding is that it is not as straightforward as this, that if one does not pay one is not on the Register. He is on the Register.

THE CHAIRMAN: That is what I thought. I thought I should make that very clear in the hearing, that although you do not pay your annual fee, if there are outstanding issues with the General Medical Council, your name is not removed from the Register until these outstanding issues are resolved.

MR PEARCE: That is exactly my understanding.

THE CHAIRMAN: Are you agreed on that, Mr Morris?

MR MORRIS: Sir, I am.

MR PEARCE: May I turn finally to the Indicative Sanctions Guidance, which I think you will have in front of you. We take up the invitation you made to address you on this guidance in this way: if I might, first of all deal with paragraphs 10 to 14 of the Guidance, which deal with the purpose of the sanctions, you will have thoroughly in the forefront of your mind the balance between the public interest identified in paragraphs 11 and 12, particularly in this case paragraph 11, in all three sub-paragraphs (a) (b) and (c), the balance between that paragraph and the public interest, on the one hand, and, on the other hand, the proportionality which is quite rightly referred to in paragraph 13.

If I might then deal in ascending order with the options available to you, first of all, it is open to you to conclude, if you do find serious professional misconduct, to conclude the case with no action. It is a matter for you whether, on your assessment of the evidence, if you find serious professional misconduct, that would be appropriate. It would perhaps be inconsistent with our submission as to the severity of what is here involved.

If I can turn to the sanctions as they are listed at page 9 onwards, in respect of reprimand,

“The sanction may be considered where most of the following factors are present:
Evidence that behaviour would not have caused direct or indirect patient harm.”

We say that that is not so. There is a possibility of direct or indirect patient harm here.

“Insight into failings.”

We say the evidence and the inferences to be drawn from the conduct of Dr Cosgrove strongly suggest he does not have insight into the failures that have been identified.

“Isolated incident which was not deliberate.”

This was neither isolated nor not deliberate.

“Genuine expression of regret and apologies.”

You do not have those.

“Acting under duress.”

Clearly, you may think there is no relevance to that here.

“Previous good history.”

Certainly, Dr Cosgrove does make out that one.

“No repetition of behaviour since incident.”

In respect of that I addressed you on the chronology and the timing of the rule 6 letter, since there has been a repetition of behaviour since the initial allegations were drawn to the doctor’s attention.

“Rehabilitative and corrective steps taken.”

There is no evidence that they have been taken.

“Relevant and appropriate references and testimonials.”

I think you are going to see a number of references and testimonials. We would submit that it cannot be said that most of those factors are present for the purposes of considering whether a reprimand is appropriate. They are, of course, not exhaustive.

I turn to conditional registration.

“No evidence of harmful, deep seated personality or attitudinal problems.”

This is an area that may cause the Committee concern, particularly the question of attitudinal problems. The Committee may be concerned that the entirety both of the evidence and of the conduct of Dr Cosgrove is rather strong evidence of attitudinal problems and an indication that those attitudinal problems are indeed deep seated.
“Identifiable areas of doctor’s practice in need of assessment or retraining.”

It may very well be that there is scope for that in respect of prescriptions and monitoring.

“No evidence of general incompetence.”

I have submitted already that patchy is the word I would use. The evidence we have adduced probably would not lead to the conclusion that the doctor was generally incompetent.

“Potential willingness to respond positively to retraining.”

All the evidence and the inferences to be drawn from the evidence suggest, in my submission, that there is neither potential nor willingness to respond positively.

“Patients would not be put in danger either directly or indirectly as a result of conditional registration itself.”

No doubt if conditional registration were considered you would seek to frame conditions so as not to put any patients in danger.

“The conditions will protect patients during the period they are in force.”

That is a matter for the conditions themselves. The last one there, when considering conditional registration, is perhaps the most difficult one.

“Is it possible to formulate appropriate and practical conditions to impose on registration?”

In my submission, it is not if you accept the argument that I advance as to deep seated attitudinal problems on the part of the doctor.

Moving on to suspension,

“The sanction may be appropriate when some or all of the following factors are apparent:

A serious incidence of misconduct where a lesser sanction is not sufficient.”

Of course, under the rules you do not get this far unless the lesser sanctions are not sufficient.

“Not fundamentally incompatible with continuing to be a registered doctor.”

We do not allege that what is proved is fundamentally incompatible with Dr Cosgrove continuing to be registered.

“No evidence of harmful, deep-seated personality or attitudinal problems.”
We submit there is evidence of deep-seated attitudinal problems here.

“No evidence of repetition of behaviour since incident.

There is some evidence of repetition.

“Committee satisfied that doctor has insight and does not pose a significant risk of repeating the failure.”

That might be a matter of some concern to the light of what I have had to say.

“Patient interests are sufficiently respected.”

You may think they would be sufficiently respected. You may conclude from that in the way we put this case, sir, that we would contend that this case does fall within the Indicative Sanctions Guidance for suspension.

Erasure on page 12.

“This sanction is likely to be appropriate when behaviour is fundamentally incompatible with being a doctor and involves any of the following:”

I have already submitted that you may think the behaviour is not fundamentally incompatible with being a doctor.

“Does it involve any of the following:

Serious departure from the relevant standards as set out in ‘Good Medical Practice.’”

You may think that “serious” is reserved for cases that are more serious than this.

“Doing serious harm to others.”

The doctor has not done that.

“Abuse of position of trust or violation of the rights of patients.”

The doctor has not done that.

“Offences of a sexual or violent nature.”

The doctor has not done that.

“Dishonesty.”

The doctor has not done that.
“Persistent lack of insight into seriousness of actions or consequences.2

There may be some lack of insight there, you may think. Clearly erasure is the most serious of the sanctions and you will have in mind all the evidence in the case, both for and against the doctor, and the issue of proportionality.

Finally, if you were minded to suspend the doctor’s registration, we would encourage you to do so on terms that there was a resumed hearing before the doctor practises again, so that the Committee has an opportunity to assess what has happened in the meantime, both in terms of the doctor’s conduct and practice. Unless I can assist further, those are my submissions.

THE CHAIRMAN: Thank you. Before turning to Mr Morris, I think it is important, and I am sure it is your wish that, although you submitted document C15 indicating that Dr Cosgrove was seeking to have his name removed from the register, we should not be influenced by this document if we come to the stage where we are considering any sanction that we might impose.

MR PEARCE: Do I take that to mean that you are asking me whether you should not assume from that document that his registration will cease in any event, so that it may make little difference to what action you take?

THE CHAIRMAN: Yes.

MR PEARCE: We would submit, yes, you should pay no regard to this. You should make the determination that is right on the evidence and your assessment of the evidence. This is a separate issue to any sanction you may impose. Precisely so, sir.

THE CHAIRMAN: Mr Morris.

MR MORRIS: Sir, I agree with that last exchange in relation to the significance of that matter. Paragraph 4 of the Indicative Sanctions says,

“Doctors practise medicine in order to serve the interests of the patients.”

I hope by the time I have finished and you have seen the additional evidence I seek to put before you that your Committee will be able to accept that this doctor, in practising as he did and making the errors that he has, which have been admitted or found proved, did so out of an overriding, albeit as you have found in some respects misguided intention to serve the interests of his patients, and that his errors do not arise out of any sense of malice or an attempt to seek personal advantage, whether financial or otherwise.

Furthermore, over reaching this case is my submission that there is no evidence, and indeed it is not put forward by the Council, that any of the patients whose care appears within these heads of charge actually suffered any harm. Indeed, the evidence will be, and is already, from the patient him or herself or from the patients’ parents or from the clinical records you have before you that Dr Cosgrove treatment of these patients transformed their lives for the better in many respects.
Sir, may I hand in at this stage a bundle of testimonials? *(Same handed)*

THE CHAIRMAN: This bundle will be D36.

MR MORRIS: I also have a small bundle of miscellaneous documents, which I think is the safest way to describe them at this stage.

THE CHAIRMAN: The second bundle will be D37.

MR MORRIS: In addressing you on the gravity of the errors that have been found proved, in my submission they fall into two categories, namely, the errors in the monitoring/giving of advice to colleague clinicians in relation to the monitoring of medication on the one hand, and the letters of complaint sent to patient GPs with copies to the clinician being complained about and to the patients.

Dealing first with the findings that you have made in relation to monitoring deficiencies and advice deficiencies, I hope that I can fairly categorise them as in all the circumstances not being very serious deficiencies. May I first of all run briefly through the findings that you have made in relation assessment of weight, height, blood pressure and other monitoring aspects, just to hopefully put the findings into context.

In relation to patient A, whatever his failings in relation to that patient, the undisputed fact of the matter is that Dr Holme, a paediatrician, did throughout the period exercise a monitoring function specifically in relation to the Ritalin medication, which I would submit puts into context the finding in relation to the failure to make an adequate assessment of the patient’s weight and the failure to advise the patient’s general practitioner to monitor the patient, as recommended in the above heads of charges.

In relation to the failure to warn the patient’s mother about Clonidine and the deleterious effect that that might have if sudden withdrawal occurs, again can I seek to put that into context by citing to you what Professor Taylor had to say about that? I do not ask you to turn it up. It is day 9 of the transcripts at 28H to 29A. Talking about the hypertensive rebound if Clonidine is stopped, he said this:

“It is a concern, not an established fact, that fluctuations in blood pressure on Clonidine have not been charted specifically. The reason for the recommendation of steady dose is from the point of view of avoidance of hazard rather than a hazard that has actually happened.”

Sir, moving on under this head of “monitoring/advice” and going to patient C, the failure found there is the fact that the letter sent to the general practitioner did not contain any advice about the appropriate monitoring of Master C. Again the fact of the matter is that on the undisputed evidence of Mrs C, Dr Rackham, the patient’s GP, did indeed monitor the patient’s blood pressure, height and weight.

In relation to patient D, the failure to make proper arrangements for monitoring the effects of the treatment that Dr Cosgrove provided for that patient, you will recall that the doctor was unable to continue telephone monitoring after July 1996 because he did not have the new telephone number for this patient or the patient’s mother, and the
responsibility for prescribing and monitoring the medication thereafter went solely into the hands of Dr Spence, as was confirmed by Mrs D when she gave evidence to you.

Specifically in relation to Risperidone, it is perhaps significant to point out that in his second letter of 17 July – again I do not ask you to turn it up but it is in divider 6 of C8 at pages 5 and 6 – he pointed out to the patient’s then general practitioner, Dr Taylor, which was shortly before the transfer to Dr Spence, the fact that the Risperidone had side effects.

Finally, the remaining defect as found in relation to monitoring and advice relates to patient G, where it has been found that he did not make an adequate assessment of the patient’s weight and did not monitor the patient’s growth. What is clear is that the mother was alert to the loss of weight of her son of one kilogram since the beginning of medication in February, running up to May. Indeed, you have in D37 at pages 4 and 5 a commentary from the mother about Dr Cosgrove’s practice, care and treatment, where she describes her struggle in relation to getting treatment for her son’s behaviour. At the bottom of that page she says this:

“I do not blame Dr Cosgrove for my son’s weight loss. This is a known side effect of Ritalin. Had his weight dropped to what I felt to be unacceptable, I am more than capable of expressing my opinion and would have asked Dr Cosgrove to adjust the dosage.”

Sir, again putting the finding into context, this was a patient whose mother was fully aware of the possible consequences and known side effects of the medication that Dr Cosgrove was putting her son on.

Sir, may I make two further general remarks about the defects in monitoring and giving advice? Concern was expressed by Professor Taylor that some of these patients, it would appear, were being monitored without any direct receipt of documentation from the schools and that the reports from schools were being filtered back through the parents, with the twofold risk that the school might not give a fully balanced picture in relation to the child for the understandable purposes of encouraging the parents and, secondly, that the parent in relating the material on to Dr Cosgrove might be influenced by what the parent had observed at home, and that this was particularly important in the context that whereas a certain level of medication might be appropriate in order to control behaviour, there may be grounds for thinking that a different level of medication might have to be balanced against that in order to secure continuing attention and cognitive function at school.

I hope that when you have had a chance to look at the testimonials that have been put before you, you will see in many cases parents speaking of not only a marked improvement in behaviour but also of academic performance at school, which would tend to suggest that the medication was not hindering on that front. Indeed, you have the specific evidence of Mrs C that from her perspective she felt that the introduction of medication kept her son in mainstream schooling when otherwise he would have gone up a different and more depressing cul-de-sac.
Secondly, and perhaps most importantly of all, and particularly in terms of the concerns expressed by Mr Pearce on behalf of the Council of a deep-seated attitudinal problem by the doctor, I submit that whereas there may well be grounds for saying that in relation to his attitude to his fellow clinicians and their approach to the diagnosis and treatment of ADHD, it does not apply in this context of the monitoring of patients. I say that because of patient A and his response to the problems that patient A met or underwent.

Sir, at page 68 of C12, the doctor wrote to Dr Holme in July 1999. You will recall the evidence that this letter was written after Dr Holme had written about his concern about the very high level of medication and the tachycardia that he had detected, and had not only copied that letter to him but had also telephoned the doctor to discuss the matter with him. That letter of 3 July, in my submission, is important in the context of what I am saying. In my submission, it clearly shows that when Dr Holme made contact with him and expressed his concerns, the doctor did not pooh-pooh them. He did not take a rejectionist attitude but he listened to the concerns and acted on them.

First and foremost, he ensured that the patient and mother came to see him. He confirmed the high blood pressure that the doctor had found and conceded that his figures clearly corroborated the 120-minute figure that Dr Holme had obtained. He acknowledged that the probable cause from his perspective for the tachycardia was the Ritalin or Methylphenidate, and he acknowledged that it could not be ignored and told the mother such. Notwithstanding that a previous reduction in medication had led to deteriorating behaviour, he took the view that the level of medication had to be reduced and indeed asked her to reduce it to 100mg per day.

In that context, it is perhaps noteworthy that some years later when this patient was sent to Professor Taylor for a second opinion, the advice coming from the Maudsley in relation to that was that the medication was appropriate up to a level of 90mg per day. Furthermore, in specific terms of monitoring, he acknowledged the need for closer monitoring of the pulse rate and made arrangements for the patient’s godmother, a nursing sister, to do that, together with giving the advice that, in order to have corroboration of those figures, the family should get the pulse rate readings checked at the surgery. Therefore, this is a doctor who, when concerns are put to him and discussed with him reasonably, responds reasonably to those concerns and takes action and increases the level of monitoring.

Sir, can I now turn to the second band of findings that you have to deal with, which are the complaint letters that he wrote to colleague professionals? Obviously, one has to accept that there were far better ways of seeking to put over his opinion that the treatment that his patients had received prior to coming to see him was poor and that, arising out of a lack of information or knowledge about the condition and the benefits of medication, those concerns could have been communicated in a much more effective and less harmful way.

Can I again seek to put in context what was going on here, not as an attempt to excuse his conduct but as an attempt to explain it? Professor Taylor readily accepted that Dr Cosgrove was a pioneer in the development of the broader application of medication to this condition both in children and particularly in adults.
He agreed that the doctor had in the past suffered both media and professional hostility even though the treatment that he was promulgating was well-founded scientifically, and the reference for that is Day 9, Page 20 at Letter C.

He also said that it would be fair to say that there would be a large number of clinicians still in the late 1990s who were adopting the restrictive approach to the treatment of ADHD by medication which was not really justified by the evidence, and it would appear that that reluctance by large numbers of his fellow clinicians still persists to this day notwithstanding the considerable growth of ADHD Clinics that Professor Taylor talked about.

The reason I make that submission is the extraordinary divergence between practice in the United Kingdom and practice in the US which Professor Taylor discussed at Day 9, Page 19, Letters D to E. He said that since the '90s there had been a change and rates of prescription have been rising substantially since 1995 and so there is probably now something like a one-third of one per cent chance of receiving the medication. However he acknowledged that that was a very much lower figure than the figure in the US, which he put at something in the order of five to seven per cent, and therefore the use of medication in the US was 20 times as common as the use of medication in this country.

That reluctance of approach by his fellow clinicians, bordering on hostility on occasions, raises its head I suggest in respect of some of the clinicians he had to deal with, or directly deal with, in particular cases that you have before you today.

You will recall a letter in C12 at Page 89, and again I do not ask you to turn it up, from Dr Vereker to Mrs A, where it was clear from that letter that Mrs A had perceived rightly or wrongly that there was bad feeling on the part of Dr Vereker, the previous treating psychiatrist, at the transfer of the patient's care to Dr Cosgrove.

Also in C12, at Page 42, there is a letter written by the Consultant Paediatrician, Dr Lwin, on 5 July 2000 to Dr Barnes, another consultant paediatrician within the hospital, where he says:

"I understand that Dr Holme referred Patient A to you before he left. A's adopted mother is aware of this and has already received correspondence ... [please] could you offer A an appointment, please",

and there is a handwritten response to that on that letter, from I would submit clearly Dr Barnes, in which he says:

"I do not see children being treated by Dr Cosgrove",

and a double exclamation mark.

Now in discussing Patient C Professor Taylor said that, and I think this was of general application, there was a need to attempt to get a shared care arrangement so that both behavioural training and with psychological input could be combined with treatment by medication, and that that ought to be feasible and that no Trust would be so obdurate as to
stand in the way of that.

Well again on the ground I submit that things are a little more difficult than that, because you have at D37 a letter at Page 2 from Dr Moses to the GP, Dr Rackham, dated 1 July 1999. Now that was written before the diatribe letter, if I can put it like that, of the 7th or 9th July from Dr Cosgrove to her, and so she had not received that letter yet, and she was talking about what had happened when the patient's mother had taken the patient to see Dr Cosgrove. The penultimate paragraph:

"Unfortunately, when C's mother took his to see Dr Cosgrove, staff felt that their behavioural management of C and entirely undermined. I could only agree with this, in particular as C's response on the morning after he had seen Dr Cosgrove was to explain the piece of aggressive behaviour by saying that he had ADHD, as if this excused him from any responsibility for his behaviour.

C was thus discharged from Pollards Well prematurely, in that we were expecting to work with him until the end of the summer holiday".

So, summarily discharged from further behavioural therapy and no attempt to see if it could be combined with Dr Cosgrove's treatment, and so these were the problems and obstacles that were being put in Dr Cosgrove's path when he treated patients with medication.

It goes on, because you will recall the history in relation to Patient D. After 1996, when care was exclusively confined to Scotland and Dr Spence, none of the clinicians in Scotland who all knew that Dr Cosgrove had initiated the treatment with medication sought to make contact with him to discuss the problems that Dr Spence was having. Dr Spence himself, without reference to Dr Cosgrove, increased the dosage up to 60 mgs a day from the final dose that Dr Cosgrove had established at 35, had tried Clonidine instead of Risperidone, had reinstated Risperidone when Clonidine did not appear to work at an increased dosage of 4 mgs a day and even noted in his notes what to do, and went on to substitute Dexamphetamine for Ritalin again with no positive results. No attempt to communicate with the doctor to seek his advice on medication in a field at which it was acknowledged he would have had a lot of experience.

And in relation to Patient H, Dr Dover, the consultant in child and adolescent psychiatry, and this is particularly germane in the context of Professor Taylor talking about the need if only to try and persuade existing clinicians about the desirability of a trial of medication. At Pages 6 to 8 you have an extract from that patient's notes, and on 26 June 2002 the Community Psychiatric Nurse had written to the patient's GP, Dr Patel, informing him of the current situation in relation to the boy and this was before Dr Cosgrove came on the scene:

"In brief you are fully aware of our ongoing involvement with this family over a period of time. Family/parent appointments were recommended and have been ongoing intermittently
following our detailed assessment ...

Unfortunately Mr H is not at present accepting of the above and has 'demanded a trial of Ritalin tablets for his son'. Such has been discussed with Dr Dover, Consultant ... who does not believe that there is sufficient evidence to warrant the prescription of medication".

Dr Patel then writes on Page 7 to Dr Dover saying that:

"H's parents are concerned again. Come to see me for lots of problems at home and school of overactive interest in adult life, sexuality, naughty behaviour, and intolerable habits ... I should write to you to take this matter somewhat differently and more seriously ..."

And then Dr Dover responds to that on 15 July on Page 8 saying:

"I have already met with the family personally and they have been assessed in detail by a number of different professionals within our team ... At present it is not appropriate for me to offer H an appointment with myself as there is no role for medical treatment in his behaviour problems".

So, a professed reluctance from Dr Dover even to consider a trial of medication at the request of parents who clearly are having an extremely difficult time with their child.

That is the background as Dr Cosgrove sits in his clinic in Bristol and receives a constant flow of patients from all across the country, coming in to his clinic displaying distressing symptoms which have been graphically highlighted in evidence before you both by Mrs D, and you will recall her description of her son jumping on the furniture, and Mrs C who gives a description of during the consultation with Dr Cosgrove of her son kicking, thumping, pulling her hair and pulling the blinds in the surgery down. All coming to him for what is acknowledged is appropriate treatment at his hands, when they could ill afford the journey and the fee that he had to charge, and this was going on year after year and one can perhaps understand the sense of frustration he felt that good scientific evidence was being ignored by a large number of consulting psychiatrists in this country which effectively should have put him out of a job.

And so one has a background that in his mind the clinicians who had been dealing with patients who subsequently came to him were unwilling or unable to take on board the new reality and the new evidence and to adjust their practice accordingly, and it is in that context that he writes these unacceptable letters to them.

Can I turn to what harm was caused by the sending of those letters. There is no evidence, in my submission, that those letters caused any disruption to the treatment patterns available to the children or patients concerned. There is no suggestion that, but for the sending of that letter, the patient would have been treated differently. You will recall, for example, the fact that Dr Moses says that Patient C was discharged from Pollards Well
before the letter was written.

It is acknowledged, and was accepted, that those letters raised the likelihood of the reader doubting the knowledge and skills of the clinician. All those patients and those patients’ parents had already, you may think, been disillusioned with the standards of care that they or their children or child had received before they first consulted Dr Cosgrove and before the letter was written.

Certainly it caused embarrassment and difficulty to the clinicians concerned to have his comments communicated not only to the clinician but to the patient's General Practitioner and the parents themselves and that cannot be excused but, on the other hand, it did not in my submission impact or give rise to any risk in my submission that it would impact on the actual care of that patient.

Sir, can I then turn to the Indicative Sanctions Guidance, which obviously you have to bear in mind when formulating what to do with the doctor, and by way of preamble perhaps in Paragraph 13 there is some guidance as to how to approach the mitigation and material that is before you at this stage in relation to serious professional misconduct and sanction.

You will see there that the Committee, it is said, will need to consider any mitigation in relation to the seriousness of the behaviour in question and the extent to which mitigation should influence judgment on a finding of SPM and then on sanction. That is a reflection of the rules, clearly, because your decision on SPM is only taken after you have heard all the mitigation. That was reinforced by the Privy Case in the case of Silver, where they said that it is axiomatic that after the findings of fact all the relevant circumstances must be considered before a finding of serious misconduct can be arrived at.

Turning to sanctions, the purpose of sanctions, as my learned friend has alluded to, is set out in paragraphs 10 onwards, the protection of patients and the public interest. If I can go to the headings that my learned friend visited under the heading of “Suspension” which he sought to discuss with you and address to you, he did not characterise on the behalf of the Council that this was a serious incidence of misconduct in the particular context of that list of factors. He did not contest that the doctor’s behaviour was fundamentally incompatible with continuing to be a registered doctor. He suggested there was evidence of deep-seated personality or attitudinal problems.

It is clear from everything you have read and seen that the doctor, in relation to his fellow clinicians, has taken a firm and unyielding line in relation to their conduct as he sees it. He has taken that line from a deeply held belief that they have got it wrong and, by getting it wrong, they have caused many patients and many patients’ families many years of misery. I have no doubt that were he here today he would plead guilty to that. As I have hopefully set out in my submissions, I question to what extent that approach has caused harm to patient care.

In relation to insight, it may be said that he does not have insight in relation to that particular problem, but it cannot be said, in my submission, that he does not have insight and is unable to respond to concerns about monitoring and the giving of advice. Again, I cite his response to Dr Holmes’ letter when Patient A was developing a tachycardia
problem.

In particular, the last entry under “Suspension”,

“Patients’ interests sufficiently respected.”

Dr Cosgrove clearly has sought always to respect his patients’ interests to the best of his ability. In so doing, you may think he has overstepped the mark in his dealings with other clinicians.

Sir, can I finally turn to the testimonials themselves that really speak more eloquently than I ever could? I ask you to look carefully at all of them when you go into camera, but can I just flag a few up with you particularly. The first one at pages 1 and 2 is from Dr Hartman, a Pathologist, who had recently become a patient of the doctor in 2004, this year. Clearly, he is a clinically well educated person in the context of the condition itself, about which he has clearly read widely. He points out at the end of the first paragraph,

“There is an enormous evidence base for these consequences…”

that is to say the consequences of not treating this condition by medication,

“…and these form the foundation of the NICE and SIGN guidelines for the use of methylphenidate in childhood. An active public and professional education campaign is starting to occur in the United States of America, but has yet to occur in the United Kingdom. I attempted to find a healthcare professional in the United Kingdom with experience and expertise in diagnosing and managing adult ADHD. I was able to find the names of only two such physicians, one of whom is Dr Cosgrove. This demonstrated to me that Dr Cosgrove is one of two doctors currently able to provide a service for an estimated 250,000 adults with this condition in the UK.”

He goes on to say,

“My inability to pay was no impediment to my seeing Dr Cosgrove as a patient. Dr Cosgrove spent more time with me than I had ever been granted by any healthcare professional previously and drew up a targeted treatment plan at the end of the appointment with clear telephonic follow up appointments.”

In the subsequent paragraph he talked of an extremely thorough telephone interview which lasted for close to an hour, again highly targeted, before issuing him with a follow up prescription. He concedes that, after initially being somewhat sceptical about telephonic follow up,

“I was left in no doubt that such a means of follow-up is an extremely useful means of patient follow-up and indeed, it must surely be necessary given the number of patients which Dr Cosgrove must care for.”

He came to the conclusion, from the perspective of a patient and a medical doctor, that there was no doubt that patient welfare is Dr Cosgrove’s foremost priority and that Dr
Cosgrove has no mercenary or self-aggrandising motives that he was able to discern. Although he had not seen the content of the letters that had been written by Dr Cosgrove to colleagues, he firmly believed that any letters written would have been written because he cares passionately for his patients and would be trying to educate other healthcare professionals, patients and their families and it would not be for personal gain.

I missed out a passage at the end of the second paragraph on the first page, a little incident that happened on the Friday evening of his consultation, when he asked Dr Cosgrove why he was not preparing to leave, he told him he had another patient and their family who were travelling from Scotland. When he looked surprised he was willing to see a patient so late on a Friday evening, Dr Cosgrove simply said, “I cannot see any patient suffer.” That Dr Hartman found profoundly moving.

Miss Roue wrote in defence of Dr Cosgrove at pages 3 to 5. She talks in the third paragraph of her son’s physical development being monitored by both themselves and his GP. His growth and weight were carefully watched. His blood pressure was checked regularly. She talks of the considerable time he spent discussing the prescription of Risperidone for the child in a subsequent paragraph. Over the page she says in the third paragraph down,

“My son is a shining example of how a child with ADHD can be a high achiever and with the right care can cope with his condition and succeed. He has been treated by Dr Cosgrove since starting school and our son has just this week managed to pass his 11+ exam. He passed within the top 90. He is a happy child with high self-esteem. He is top of his class and with the medication is able to concentrate on his written work which he needs to produce to demonstrate his intelligence. Without medication he cannot do this.”

Carrying on on the academic school front, she goes on to talk about two godsons who also had ADHD. Within two weeks of starting medication their schools were reporting a huge improvement in course work. She goes on to say at the bottom of the page,

“I am not some deluded individual who has in any way been hoodwinked by some devious doctor. I am an intelligent and rational person who has researched my son’s condition widely.”

Can I take you on to page 20, which is a statement from Musa Idris? In the middle of the page,

“Telephone appointments are always extremely in depth – concerning weight, eating and sleeping patterns, diet and current medication dosage. In fact, on one occasion when Musa missed an appointment, Dr Cosgrove refused to send a repeat prescription until a follow-up appointment had been made.”

So the monitoring process was a real process. If it did not proceed, it meant that Dr Cosgrove would not prescribe.

On page 22 there is a letter from Anna Richardson. She talks about the problems her child was having. In the second paragraph,
“Eventually I took my son to see an NHS Consultant who told me that there was no treatment available other than behaviour therapy (that I had been doing anyway). This Consultant frightened me into believing that prescription treatments for this condition would leave my son ‘doped’ and in danger, he recounted horror stories in the USA and worried me.”

That is another illustration of the hostility that still persists in parts of the profession.

At page 37 there is a note from Venetia Hill.

“I am very grateful for Dr Cosgrove’s practice, care and treatment because no other psychiatrist has given me such confidence. I was very frightened of putting my son on medication and effectively resisted for 14 years, but at a terrible price with my son becoming violent and the police having to be called sometimes. No amount of behaviour therapy has had the same effect of helping my son concentrate as the medication.”

The patients and parents of patients who are coming to Dr Cosgrove are not coming out of a sense of “Medication is the answer. It gets us off the hook as responsible parents. We are not to blame”, and leaping at the prospect. Patients and parents have been deeply sceptical about the use of medication in the treatment of their children.

Sir, Dr Cosgrove, in my submission, clearly cared, perhaps not wisely but too well for his patients, but over the years he has done a great service to a large swathe of sufferers from this syndrome who have been deprived of appropriate care, notwithstanding the proper evidence base on which he was acting. In my submission, there remains a continuing place in medicine for this doctor.

THE CHAIRMAN: Thank you very much. At this point I will turn to the Legal Assessor.

THE LEGAL ASSESSOR: Once again, I have prepared a written advice which I propose to read into the record. I am grateful to both Counsel for their comprehensive addresses, because it has reduced what I have to say to the Committee.

These proceedings have now reached the point where the Committee has to determine whether the proved and admitted facts, taken with the evidence adduced by the parties under rule 28 is such that they find Dr Cosgrove guilty of serious professional misconduct. I repeat part of my earlier advice as to what constitutes serious professional misconduct. It is conduct which has a link with the practice of medicine and which, in the circumstances of the case, represents a serious – and I stress that word – breach, whether by omission or commission, of the rules and standards, written and unwritten, ordinarily required to be followed by a registered medical practitioner.

The Committee is charged with whether they find Dr Cosgrove guilty of such conduct. I advise that if, after anxious consideration of the proved and admitted facts of the charge, and what I shall call compendiously the rule 28 evidence, they are left in any real doubt as to whether Dr Cosgrove is guilty of serious professional misconduct, then he should
have the benefit of that doubt.

In the event that Dr Cosgrove is found guilty of serious professional misconduct, the question of sanction by means of a direction concerning his registration then falls to be considered. The way in which the Committee approaches this is governed by law. The applicable law is to be found in the Statutory Instrument SI 1988 12255, more commonly known as the Professional Conduct Committee Rules. It has the force of law and the authority of Parliament. The relevant law is to be found in rules 30 and 31.

The Indicative Sanctions Guidance is a highly relevant document. Its provisions may properly be referred to and given great weight by the Committee, but it is guidance and not law. This has two consequences. The first is the one that whilst the guidance must be taken into account, Dr Cosgrove’s case must be considered on its own particular facts and the appropriate decision reached on those facts.

Secondly, if there is a conflict between the procedure laid down by Parliament in rule 30 and rule 31 and the Indicative Sanctions Guidance, it is the rules that must be given preference.

With this in mind I advise the Committee that they should try, if at all possible, to reach a decision suited to the facts of this case which is both in accordance with the rules and in harmony with the Indicative Sanctions Guidance.

Rule 30(1) requires the Committee to consider whether they should postpone the determination or whether to make a direction. If the Committee do not consider that this is necessary, then it has to consider whether it is sufficient to make no direction. Although this is not named in the rules, this course amounts to a reprimand. If a reprimand is not sufficient, then the Committee must consider whether the imposition of conditions on the practitioner’s registration lasting for not more than three years for the purpose of protecting members of the public, which of course includes patients, or for his own interests, is sufficient. If and only if the Committee consider that the imposition of conditions is insufficient will the Committee go on to consider whether they should exercise their powers to suspend Dr Cosgrove’s registration for a period of up to 12 months. Lastly, I repeat and emphasise that if and only if suspension is considered to be insufficient should the Committee exercise their power to erasure. This is the scheme of the imposition of sanctions laid down by Rule 31.

It may be fairly asked what is meant by the word “sufficient”. My advice is that it means “proportionate”. A sanction will be proportionate if it is no more than is necessary to achieve one or more of the following objectives: the protection of the public, again of course including patients; maintaining public confidence in the maintenance of proper professional standards by the self-regulation of the medical profession; and the interests of the practitioner himself. This list is not exhaustive.

A number of specific points need to be made about the application to the doctor of proportionality. First, it is not legitimate to impose a sanction merely to punish a practitioner. A sanction may be imposed for a legitimate purpose, the inevitable consequence of which may well have a punitive effect – for example, loss of employment on erasure or suspension – but in such a case the Committee must be satisfied that such an
erasure or sanction is no more than necessary to protect the public or to achieve some other legitimate purpose.

Secondly, maintaining the reputation of the medical profession is frequently said to be such a legitimate objective, and indeed it is. However, this does not mean simply the standing of the profession in the eyes of the public considered in isolation. The legitimate objective to be pursued is rather that the profession’s reputation is truly maintained, in the sense that an informed public perceives and is both reassured by and justifiably confident of the fair, transparent and effective regulation that the medical profession operates to ensure that it can truly be said that both the public and the public interests are protected by it.

Lastly, my statutory remit is to advise the Committee on points of law. The Committee are not obliged to follow my advice. Should they decline to do so, I advise that it be stated expressly in their determination that they decline to do so and the law that they do in fact apply. The reason for this is so that Dr Cosgrove and anyone advising him can then be certain of what law was applied in his case.

That is my advice.

THE CHAIRMAN: Can I seek clarification of one point that you made? I may have picked it up incorrectly, but I thought I heard you say that if the panel found the doctor guilty of serious professional misconduct and were minded to take no action against his registration, this was a reprimand. My understanding is that the panel can take no action against the doctor’s registration or offer a reprimand. I thought that was what you had said, Mr Pearce.

THE LEGAL ASSESSOR: Sir, just to reply to that, I may very well be in error. I thought that if no action was taken, that constituted a reprimand. I would be grateful for any guidance that counsel can give me on that.

MR PEARCE: I think the Indicative Sanctions Guidance suggests that there are two different things involved here.

THE CHAIRMAN: I would refer you to paragraph 8.

MR PEARCE: Paragraphs 8 and 15. Paragraph 8 makes the point that the Procedure Rules do not require the Committee to impose a sanction, so it is thus open to the Committee to conclude the case without a reprimand, namely, the lowest level of sanction. That paragraph therefore suggests that one can have no action, which is as it were resolved on a reprimand. My understanding is that the panel can take no action against the doctor’s registration or offer a reprimand. I thought that was what you had said, Mr Pearce.

THE LEGAL ASSESSOR: My approach is that I do not think the word “reprimand” is actually mentioned in the rules, but it seems to have acquired an existence of its own before this Committee. I stand corrected in that sense and I would alter my advice. It
appears to be a course open to the Committee to take no action and, if that is not sufficient, they can go on to reprimand, in which case my advice is that you should simply insert “no action” into the scheme of ascending actions that may be taken by the Committee in response to a finding of serious professional misconduct. However, I stress that the first stage is to consider whether you find Dr Cosgrove guilty of serious professional misconduct. I am grateful to the Chairman for drawing that to my attention.

THE CHAIRMAN: Mr Morris, do you have any view on what has been discussed?

MR MORRIS: Sir, no. I respectfully agree that there are two aspects to conclude the matter. If one goes back to the statute, Rule 30(2) states that if the Committee decide that no such postponement, that is, where the option of postponement is considered, is necessary, they should consider and determine whether it shall be sufficient to make no direction and conclude the case and that, if they so determine, the Chairman should announce that determination. Rule 31 goes on to set out various directions, which, of course, start with conditions and go on up the ladder. It would therefore appear that the practice that has arisen of either taking no action or issuing a reprimand both fall within Rule 30(2).

THE LEGAL ASSESSOR: In my advice I said that although it is not named in the rules, the reprimand does not exist. I am frequently accused of being perhaps a trifle over-legalistic, and I think it would not be correct for me to argue that the reprimand simply does not exist because it is not mentioned in the rules, but if perhaps I can just clarify it, the ascending order will then be: no direction; reprimand; conditions; suspension; erasure.

THE CHAIRMAN: I think we are all agreed on that.

THE LEGAL ASSESSOR: I am grateful.

THE CHAIRMAN: The Committee will now go into camera.

STRANGERS THEN, BY DIRECTION FROM THE CHAIR, WITHDREW AND THE COMMITTEE DELIBERATED IN CAMERA

STRANGERS HAVING BEEN READMITTED

THE CHAIRMAN: Mr Morris, at all material times, Dr Cosgrove was practising as a Consultant Child and Adolescent Psychiatrist working in private practice at the Bristol Priority Clinic. The Committee have considered the cases of a number of patients seen by Dr Cosgrove between May 1996 and January 2003. These patients were both adults and children and were diagnosed as suffering from Attention Deficit Hyperactivity Disorder (ADHD). Dr Cosgrove prescribed drugs to these patients but did not take appropriate steps to monitor the patients whilst they were taking the drugs prescribed and as such acted irresponsibly and not in the best interests of the patients.

The Committee have further found proved that on a number of occasions Dr Cosgrove sent letters to other practitioners who were involved in the care of the patients he had seen and copied these letters to the patients or their parents. In those letters he made
The Committee have also found that in or around August 2000, Oxfordshire Mental Healthcare NHS Trust carried out an investigation into a number of features of the treatment of a patient of the Trust, Patient E. On 29 September 2000, Miss Wendy Samways, Complaints Manager at the Oxfordshire Mental Healthcare NHS Trust, wrote to Dr Cosgrove requesting copies of his clinical notes concerning Patient E and enclosed signed authorisation for the release of the records. Dr Cosgrove replied to this request by letter dated 3 October 2000, stating that he would not supply the medical records. The Committee have heard that Dr Cosgrove and Mrs E came to a shared agreement that the records should not be disclosed and for that reason the Committee did not find that his failure to supply the medical records was inappropriate or unprofessional. Nonetheless, the Committee found that Dr Cosgrove acted unprofessionally and made unsustainable comments in his letter dated 3 October 2000 to Oxfordshire Mental Healthcare NHS Trust. These comments were likely the cause the reader of the letter to doubt the knowledge or skills of the employees of the Trust who treated Patient E.

The Committee acknowledge that throughout the course of this inquiry there has been no criticism of Dr Cosgrove’s prescribing practice to those patients whom he diagnosed as suffering from ADHD. Instead, this case has been centred around Dr Cosgrove’s monitoring of those patients whom he diagnosed as suffering from ADHD and the letters he subsequently sent to other practitioners involved in the care of those patients. The Committee are concerned about the evidence adduced in relation to Dr Cosgrove’s management of patients to whom he had prescribed drugs.

Professor Taylor, a Child and Adolescent Psychiatrist, attended to give his expert opinion on these matters. He has told the Committee that it is necessary to undertake a physical examination, including height, weight and blood pressure of patients who are taking Ritalin and Risperidone, in order to determine whether continued prescribing is appropriate.

The Committee have had regard to the European Child and Adolescent Psychiatry Clinical Guidelines for Hyperkinetic Disorder, 1998 on monitoring patients to whom Ritalin is prescribed and to Professor Taylor’s protocol for the monitoring of patients to whom Ritalin in doses of up to 60 mg per day is prescribed. They have found that Dr Cosgrove’s monitoring of patients over the telephone was not sufficient to obtain relevant information for the monitoring of patients and prescribing of Ritalin and fell short of the standards of monitoring which both the European Guidelines and Professor Taylor’s own protocol recommend.

The Committee have heard that an initial consultation was carried out on a face-to-face basis and that Dr Cosgrove usually undertook follow-up consultations over the telephone. Whilst some information can be obtained by means of a telephone conversation, this is inadequate for the totality of monitoring which was required for these patients. The Committee acknowledges that whilst some of the patients’ GPs were undertaking some monitoring, this was not undertaken to its fullest extent, nor did Dr Cosgrove give explicit instructions for the monitoring of these patients. The Committee note that Dr Cosgrove also made informal arrangements for the parents to undertake some monitoring of their comments which were unprofessional, unsustainable and likely to cause the reader to doubt the knowledge and skills of the practitioners referred to within the letters.
child. However, the Committee consider that those arrangements were inadequate and unacceptable. The Committee consider that Dr Cosgrove was the prescribing practitioner and as such was responsible for the proper monitoring of his patients. In not doing so, he failed to discharge his duties in being responsible for those patients.

The Committee have also heard evidence from a number of witnesses with regard to certain of the correspondence that Dr Cosgrove sent to other medical practitioners, patients or their parents. The Committee have found that the nature of this correspondence goes far beyond what amounts to robust criticism and that he acted in a wholly unprofessional manner in sending those letters. The Committee consider that he was not in possession of all of the facts pertaining to the issues dealt with in the letters when he made his judgments and as a consequence he persistently undermined the opinions provided by and the standing of other practitioners involved in the care of the patients for whom he prescribed. Furthermore, in copying those letters to the patients or their parents and GPs of patients, he undermined future patient/doctor relationships and the further proper medical care of these patients.

The Committee consider that in sending those letters, that Dr Cosgrove breached the principles contained with the GMC publication “Good Medical Practice”. The October 1995 and July 1998 editions state:

“You must not make any patient doubt a colleague’s knowledge or skills by making unnecessary or unsustainable comments about them”;

and, in similar terms, the May 2001 edition states:

“You must not undermine patients’ trust in the care or treatment they receive, or in the judgment of those treating them, by making malicious or unfounded criticisms of colleagues”.

The Committee have considered all the submissions made on behalf of Dr Cosgrove, including those of Mrs C and Mrs E, who attended the hearing. It has been submitted that Dr Cosgrove in treating his patients considered that he was acting only in their best interests. It has further been submitted that Dr Cosgrove did not act out of malice or to gain personal advantage. There has been no evidence before the Committee that suggests that any patients suffered harm as a result of Dr Cosgrove’s actions. The Committee have also read and carefully considered the many testimonials which demonstrate that Dr Cosgrove is well respected and held in high regard by his patients. There is no doubt that Dr Cosgrove considered that he had the best interests of his patients at the forefront of his mind.

Whilst the Committee acknowledge the difficulties that Dr Cosgrove faced within the profession with the regard to the recognition of ADHD and its treatment with medication, this cannot justify his failure to discharge his duties as a treating consultant and cannot be used as an excuse for his lack of patient monitoring and attitude towards colleagues.

Dr Cosgrove as a consultant should have working to the highest standards and should have demonstrated good standards of care. All patients are entitled to receive good standards of practice and care from their doctors and the practice of medicine involves
teamwork at all levels. Patients and colleagues are entitled to be treated properly and considerately. Dr Cosgrove did not demonstrate this consideration. The Committee have found that he repeatedly, through correspondence, made unsustainable criticisms against other medical practitioners and cast doubts on their clinical competence.

The Committee have considered all the matters and judge Dr Cosgrove’s behaviour to be a serious departure from the standards of care and conduct expected of a registered medical practitioner. The Committee find Dr Cosgrove guilty of serious professional misconduct.

The Committee have noted the letter from Dr Cosgrove dated 16 March 2004, in which he states that he has now retired from medical practice. Despite this, the Committee note that Dr Cosgrove remains on the Medical Register as a fully registered medical practitioner. The Committee are therefore bound to decide what action to take, if any, concerning his future registration with the GMC.

In doing so they have carefully considered the issue of proportionality. It is the duty of this Committee to protect patients and maintain public confidence in the medical profession. It is the Committee’s duty to ensure that the public continues to have confidence in self-regulation of the medical profession and that the reputation of the profession is upheld.

The Committee have considered the range of sanctions available and have also taken account of the advice provided in the Indicative Sanctions Guidance published by the GMC and have followed the advice tendered by the Legal Assessor.

The Committee first considered whether to conclude this case by taking no action or by issuing a reprimand. The findings against Dr Cosgrove represent a serious breach of the principles of Good Medical Practice and the standards of care and conduct which the public is entitled to receive from registered medical practitioners. Furthermore, the Committee note that further similar incidents occurred after 2002 despite Dr Cosgrove being notified of these matters by the GMC in 2002. The Committee found that Dr Cosgrove did not demonstrate insight into his failings, he has not expressed any remorse or regret for his actions and there is no evidence that he has taken rehabilitative steps to remedy the matters which have brought this case before the Council.

They have therefore determined that to conclude this case with a reprimand would not sufficiently reflect the seriousness of the case.

The Committee have carefully considered whether to impose conditions on Dr Cosgrove’s registration. They consider that any conditions should be appropriate, proportionate, workable and measurable. The persistent nature of his inappropriate and unprofessional conduct from 1996 to 2003, which included a period after which he became aware that his conduct was under review by the GMC, provided evidence of the presence of attitudinal difficulties. The Committee have had no indication of his willingness to respond positively to re-training and coupled with the difficulty in formulating practical conditions for the type of work that Dr Cosgrove undertook, the Committee have determined that any conditions would be an insufficient response to the finding of serious professional misconduct.
The Committee consider that Dr Cosgrove has not demonstrated any remorse or insight into his behaviour. The matters under consideration by this Committee have occurred over a significant period of time in particular in 2003, by which time he was aware of the investigations being carried out by the GMC. The Committee have come to the conclusion, having taken into consideration his significant departure from Good Medical Practice in several areas that it is in the public interest and to protect members of the public and the reputation of the medical profession, that Dr Cosgrove’s registration should be suspended for a period of 12 months.

The effect of the foregoing direction is that, unless Dr Cosgrove exercises his right of appeal, his registration will be suspended for a period of 12 months beginning 28 days from the date that proper notice is deemed to have been served on him.

The Committee will resume consideration of his case at a meeting to be held before the end of the period of 12 months. At that hearing the Committee will expect to receive evidence that Dr Cosgrove has addressed the problems identified throughout this determination including:

- Evidence as to how he would improve his practice towards monitoring patients whom he may treat or for whom he may be responsible;
- Evidence that he has improved his communication skills;
- Evidence that he has addressed his attitudinal difficulties.

The Committee will consider whether to take further action in relation to Dr Cosgrove’s registration. He will be informed of the date of that meeting which he will be expected to attend.

Shortly before the resumed hearing he will be asked to furnish the General Medical Council with the names and addresses of professional colleagues and persons of standing to whom the Council may apply for information as to his conduct since the hearing of Dr Cosgrove’s case.

The Committee are minded to consider the issue of making an order for the immediate suspension of Dr Cosgrove’s registration and would wish Counsel to address the Committee on those issues.

Thank you very much, Mr Morris.

MR PEARCE: Sir, for our part we would say that the matter of immediate suspension is one that lies very much in your domain to determine, save and except that those matters which lie behind your decision to make an order of suspension on the doctor's registration might themselves be taken as grounds upon which you think an order for immediate suspension is appropriate. Unless I can assist further, I have nothing to add?

THE CHAIRMAN: No, thank you.

Mr Morris?
MR MORRIS: Sir, I would submit it is not necessary for the protection of members of the public, or would be in the best interests of the practitioner to order immediate suspension in the light of his letter of 16 March 2004 which establishes that he has retired from medical practice, the clinic from which he has practised and which is the source of the actions the subject of this Committee's determination this afternoon has ceased to exist and immediate suspension is not necessary.

THE CHAIRMAN: Thank you. Does any Member of the Panel wish to raise anything with Counsel?

Legal Assessor, is there anything that you want to say?

THE LEGAL ASSESSOR: No, thank you.

THE CHAIRMAN: We will now go into camera again.

STRANGERS THEN, BY DIRECTION FROM THE CHAIR, WITHDREW
AND THE COMMITTEE DELIBERATED IN CAMERA

STRANGERS HAVING BEEN READMITTED

THE CHAIRMAN: Mr Morris:

The Committee have considered your submissions. The Committee have been mindful of Dr Cosgrove's letter of 16 March 2004 in which he states that he has retired from medical practice, however, the Committee remain of the view that he remains on the Medical Register as a fully registered medical practitioner and would therefore be able to return to medical practice in the intervening period should he so decide.

The Committee have determined that in accordance with Rule 32 of the Procedure Rules, Dr Cosgrove's registration shall be suspended forthwith. The reason for so doing is for the protection of members of the public.

The effect of this direction is that Dr Cosgrove's registration will be suspended from the date on which notice of the direction is deemed to have been served upon him.

The substantive period of suspension for 12 months, as already announced, will then take effect 28 days from the date on which notice of the direction is deemed to have been served upon him, unless he lodges an appeal in the interim.

The order for immediate suspension will remain in force until the substantive order for suspension takes effect.

That concludes the case. Thank you very much. I am sorry, it does not quite conclude the case. I should have asked the Legal Assessor to repeat a bit of advice he gave us while in camera and so I will get him to repeat that advice now. I am sorry about that.

THE LEGAL ASSESSOR: Yes. Well, I referred the Committee to Section 38 of the
Medical Act 1983. The part that was read to the Committee related to the basis on which the immediate suspension could be made. I referred them to the words which said:

"... if satisfied that to do so is necessary for the protection of members of the public or would be in the best interests of that person, may order that his registration be suspended forthwith ..."

The simple point was to make it clear that the Committee had the power to suspend forthwith, either on the basis of protecting the public, or in the interests of the practitioner.

THE CHAIRMAN: It was a simple reading of the appropriate point in the legislation.

So, that concludes the case now. Thank you.