Neutral Citation Number: [2015] EWHC 3378 (Admin)

Case No: CO/96/2015

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 23/11/2015

Before :

MR JUSTICE EDIS

- -

Between :

THE QUEEN (on the application of SHEILA ADAM)	**Claimant**
- and -	
GENERAL MEDICAL COUNCIL	**Defendant**

- -
- -

John de Bono QC and Susanna Rickard (instructed by **Hodge Jones & Allen LLP**) for the **Claimant**
Catherine Callaghan (instructed by **GMC Legal**) for the **Defendant**

Hearing dates: 13 October 2015M

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Approved Judgment

Mr Justice Edis :

1. This is a claim for judicial review by Dr. Sheila Adam. She was Public Health Director with Barts Health NHS Trust until her retirement in 2013 and was formerly Deputy Chief Medical Officer and Director of Policy and Director of Public Health for NHS London. She complains about the failure of the defendant to refer for investigation her complaint about Professor Sir Bruce Keogh, the Medical Director of the NHS. Stewart J refused permission on 1st April 2015 and the parties agreed that this hearing would be a "rolled up" hearing so that if I grant permission I will go on to determine the claim. Stewart J granted permission in respect of ten other doctors about whom Dr. Adam complained at the same time and a consent order in those cases was made before the hearing of the claim in relation to Sir Bruce Keogh.

2. The subject matter of Dr. Adam's complaint was BL who is 25 years old and suffers from Kawasaki disease. This is a very rare complaint. In 1993 he suffered negligent treatment as a result of which he recovered substantial damages. Among the consequences of that sequence of events was an arrangement whereby he was granted "open access" to the Royal Brompton Hospital. Dr. Adam was involved in arranging that in 1993/1995, but has had no involvement in his clinical care. On 15th August 2010 he presented to that hospital as an emergency but was initially declined treatment. He alleges that he was subsequently admitted but that there were delays in providing treatment and that he was not prescribed the right medical therapy. He underwent unsuccessful cardiac surgery on 23rd August 2010. There is a pending damages action against the hospital as a result of that. Dr. Adam has been aware again of BL's case since 2011 when her private contact details were disclosed to BL's father in error and he telephoned her at home. She agreed to intercede on his behalf in 2012 about the problems with the Royal Brompton Hospital which started in 2010.

3. I am concerned only with whether the decision of the defendant not to refer Dr. Adam's complaint about Sir Bruce Keogh for investigation was lawful. I will therefore confine my account of the facts narrowly to matters which are relevant to that issue. Given the other complaints about other doctors and the pending damages action it is important that I should not be understood to express any view about anything which is not material to the issue which I have to resolve. Because of the narrow focus of my task, my review of the facts is selective and limited to those which might impact on Sir Bruce Keogh.

A Review of the Facts

4. A history of the complaints which arose in 2010 is given by Professor Michael Levin in his letter of 4th October 2010 to the consultant in interventional cardiology at the Royal Brompton Hospital. Professor Levin is a paediatrician and was by that date no longer involved in BL's care, although he had looked after him throughout his childhood. He had been contacted by the family and set out their concerns. Dr. Adam met Dr. Andrew Mitchell who is the Medical Director of NHS London and discussed the case with him on 13th December 2010 and gave him a copy of Professor Levin's letter.

5. The open access issue caused disagreement between BL's family and the Royal Brompton Hospital. The family asserted that it existed and the Hospital denied knowing about it. No documents could be found which set out the arrangement in

which Dr. Adam had been instrumental. The Hospital does not provide emergency care. This generated complaints from BL's father which Dr. Andrew Mitchell sought to address. Dr. Adam's complaint about Dr. Mitchell to the GMC is now to be considered afresh under rule 4 (triage) a result of the consent order I refer to above. I am prepared to assume, without deciding the matter, that there is material in this series of events which warrants an investigation by the defendant. The issue for me is whether Sir Bruce Keogh should be the subject of that re-consideration along with others.

6. Dr. Mitchell emailed Dr. Adam on the 6th July 2011 setting out the problem and saying

> "What is the story re open access and your involvement? Paed units often offer open access as a matter of course.
>
> "Any light you can throw on this would be appreciated."

7. It does not appear that Dr. Adam was ever able to shed definitive light on the nature of the arrangement she had been involved in making.

8. In November 2011 Dr. Adam had a meeting with BL's parents and was shocked by what she was told. She decided to arrange a meeting with Dr. Mitchell. By this stage BL's father had already issued legal proceedings and Dr. Mitchell's suggestions for resolutions had been rejected. He was by now of the view that any contact between him and BL's father would have to be through lawyers. He told Dr. Adam this in an email of the 21st November 2011. By this stage the Royal Brompton Hospital was no longer looking after BL and the issue was what lessons could be learned from his experiences for Kawasaki sufferers generally and, no doubt, what legal remedies he may be able to recover. The family wanted the Hospital to be "held to account". A discussion took place on Monday 28th November 2011.

9. The involvement of Sir Bruce Keogh in the discussions which followed the events of 2010 has not been extensive. It began when Dr. Adam reflected on her discussion with Dr. Mitchell and on Friday 2nd December emailed him, saying

> "My understanding is that although you advised RBH to establish a review of the care of BL and to share the outcome with the family, they have been reluctant to do this. There has also been no progress on the development of a clinical pathway for Kawasaki Disease. The contact between NHS London and the family is now through solicitors.
>
> "The family continue to believe that there were failings in the care provided for Ben last year and that their concerns have not been properly addressed by RBH. They also consider that RBH has not been held to account.
>
> As I explained [BL's family] approached me using my contact details which were unintentionally released by NHS London. I feel that I now have a duty of care to highlight these concerns,

> and therefore propose to contact Bruce Keogh, to seek his advice about this complex case."

10. Dr. Mitchell responded saying

> "I don't think this will be helpful at all.
>
> "Am sure that Bruce will come back to me at some stage and ask for advice on the matter.
>
> "The Trust will claim that they have investigated the complaint to their satisfaction and I have no authority to counteract that. There have been independent external views given on BL's care hence his change of consultant and trust. The next phase in complaints proceedings would be to take it to the ombudsman which BL's father could do and I am sure you could support him if you wished.
>
> "The Trust has agreed to working with others to produce an appropriate pathway for KD patients which it is my responsibility to take forward. I'm not sure where your personal responsibility lies here… are you supporting the family's personal grievance against RBHT or seeking improved care for young people on this pathway throughout London – to which RBHT would be a signatory?"

11. Dr. Adam replied

> "Thanks for your email which I have reflected on over the last 24+ hours. To clarify my position: I have been made aware of concerns about the clinical care provided at [the Royal Brompton Hospital] and do not have evidence that these have been properly investigated and, if necessary, action taken. I am therefore acting within the duty of care which any doctor would have in these circumstances."

12. On 5th December 2011 Dr. Adam emailed Sir Bruce and asked his advice. Because of her previous very senior position within the NHS she was able to contact him directly. Therefore he did not become involved in this issue as a result of a formal process by which it was referred to him. But for the role of Dr. Adam, Sir Bruce would not have been involved at all, because this issue was not normally part of his responsibilities. Dr. Adam's email to him is important, because the complaint to the GMC alleges that he failed to respond properly to it, in a way which might amount to misconduct. It said

> "Dear Bruce
>
> "I would be grateful for your advice.
>
> "When I was Regional Director of Public Health with NW Thames RHA, I dealt with a complaint about the clinical care

> of a three year old with Kawasaki's Disease. There was a delay in making the diagnosis and in prescribing IgG, and the child was left with a coronary artery aneurysm. The trust did not handle the complaint well and an independent investigation was commissioned by the RHA. This confirmed the delay and the missed opportunity to provide early treatment.
>
> "Last year, now aged 19 years, the patient had a myocardial infarction which required a graft, and was treated in a second trust. The family are concerned about the delay in making the diagnosis and in instituting effective treatment. They are also unhappy about how the trust provided care, and what they perceive to be an inadequate response to their concerns.
>
> "I attach a draft letter from Professor Michael Levin who looked after the child and family following the initial diagnosis. I should emphasise that this letter was not sent but I think it does provide an excellent summary of the events last year.
>
> "The family made contact with NHS London towards the end of last year. I was contacted a few weeks ago by them…as they remain unhappy with the NHS response to their concerns, and I have now met with them. On the basis of the information which I have, it seems that the Trust has not provided the family with an appropriate response to what are potentially serious concerns. It is possible that there may be wider implications for clinical care.
>
> "It would be very helpful if Michael Levin and I could talk this through with you. Would it be possible to book a slot in your diary?"

13. Sir Bruce's personal assistant replied on his behalf on 13th December 2011 saying

> "While he has an obvious interest in clinical care, Bruce has indicated that it is not appropriate for him to become involved in an individual case at this time. Apologies."

14. That resulted in an email from Dr. Adam dated 22nd December 2011 which sought to explain that the problems went beyond the individual case of BL. She said that the lessons to be learned from what had happened to BL were relevant to all those who suffer from Kawasaki Disease. She received no response. She concluded that email in this way:-

> "I realise that, in your role, you cannot get directly involved in investigating clinical concerns or complaints. However, I believe that, as medical director for the NHS, you do have a locus in ensuring that such concerns are properly investigated. This may be via the complaints process, but as the Mid-Staffordshire inquiries show, this can be a blunt instrument. Moreover if an NHS body is aware of concerns about clinical

> care, they should take action whether or not there has been a complaint.
>
> "I am putting this on record, as I believe is my responsibility as a doctor registered with the GMC. I remain unhappy with the present position, and, of course, very happy to discuss the case with you."

15. Mr. Anthony Sumara also raised the issue with Sir Bruce by email on 13th March 2012. He was appointed Chief Executive of the Mid-Staffordshire NHS Foundation Trust after the problems arose there which were the subject of a report by Sir Robert Francis QC. He said that he thought that the case of BL and the Royal Brompton Hospital seemed to be another example of organisational arrogance. Sir Bruce did not respond to this either.

16. In a witness statement for these proceedings, Sir Bruce has said that he did take some action by contacting Dr. Mitchell and receiving an assurance that all was in order. I do not propose to take this into account in assessing the lawfulness of the defendant's decision not to investigate him. If he had a duty to act, such that a failure to act is capable of amounting to misconduct, the adequacy of his response is plainly a matter for investigation. The question for me is whether it was lawful for the defendant to decide that Sir Bruce's role was so far removed from clinical care in this respect that a decision to take no action as a senior manager is incapable of amounting to misconduct.

17. On 24th June 2012 Dr. Adam wrote to the defendant seeking advice. She was told that the GMC would not investigate. On 23rd August 2012 she wrote to Mr. Niall Dickson, the Chief Executive of the defendant to explain that the refusal to investigate left her in an invidious position. She said

> "Serious concerns have been reported to me, as a medical practitioner. My understanding is that the GMC requires any registered medical practitioner to address concerns about the practice of a colleague."

18. The defendant then instructed Field Fisher as external solicitors to investigate and they conducted a full review taking long statements from various people who were involved, including Dr. Adam. This was sent to Simon Haywood, an investigation officer at the defendant, on 13th September 2013 who forwarded it for triage under rule 4. This was carried out by Tracy Fisher, another employee of the defendant, who thought that the complainant was BL. It was, in fact, Dr. Adam, something Ms. Fisher did not realise until 2014 after further correspondence. On 26th September 2013 she sought advice from Peter Swain who is Assistant Director of Decisions and Case Review at the GMC. She asked for advice about the case of Sir Bruce Keogh and he advised her not to proceed with it. On the following day he discovered that she had referred fifteen other doctors for investigation. He intervened which resulted in those investigations being put on hold pending legal advice. On 5th December 2013 the advice was received which eventually resulted in ten of the investigations being rejected at the rule 4 stage. The five investigations which did proceed past the rule 4 stage were concluded on 15th and 16th January 2015 when after investigation at the rule 8 stage the defendant decided to take no further action in those cases.

19. On 25th July 2014 Dr. Adam, who had expressed her dissatisfaction previously, asked for a rule 12 review of the decision not to investigate in the case of Sir Bruce Keogh. That review took place and on 13th October 2014 resulted in a decision to uphold the decision to take no further action. This claim seeks the quashing of the decision at the rule 4 stage and the decision on the rule 12 review in the case of Sir. Bruce Keogh.

The relevant regulatory scheme

20. Section 35C of the Medical Act 1983 as in force in October 2014 and so far as relevant provided

> "35C.— Functions of the Investigation Committee
>
> (1) This section applies where an allegation is made to the General Council against—
>
> (a) a fully registered person; or
>
> (b) a person who is provisionally registered,
>
> that his fitness to practise is impaired.
>
> (2) A person's fitness to practise shall be regarded as "impaired" for the purposes of this Act by reason only of—
>
> (a) misconduct;
>
> (b) deficient professional performance;
>
> ……
>
> (4) The Investigation Committee shall investigate the allegation and decide whether it should be considered by a Fitness to Practise Panel."

21. Rules 4, 8 and 12 of the General Medical Council (Fitness to Practise) Rules 2004 made under section 35CC of the 1983 Act are set out in the appendix to this judgment.

22. At the rule 4 stage the Registrar decides whether the allegations, if proved, are capable of supporting a finding of impaired fitness to practise by reason of, for example, professional misconduct. Elias LJ in *R (OAO Remedy UK Limited) v. GMC* [2010] EWHC 1245 Admin analysed a number of authorities about professional misconduct and set out the principles which he derived from them at paragraph 37:-

> (1) Misconduct is of two principal kinds. First, it may involve sufficiently serious misconduct in the exercise of professional practice such that it can properly be described as misconduct going to fitness to practise. Second, it can involve conduct of a morally culpable or otherwise disgraceful kind which may, and often will, occur outwith the course of professional practice

itself, but which brings disgrace upon the doctor and thereby prejudices the reputation of the profession.

(2) Misconduct falling within the first limb need not arise in the context of a doctor exercising his clinical practice, but it must be in the exercise of the doctor's medical calling. There is no single or simple test for defining when that condition is satisfied.

(3) Conduct can properly be described as linked to the practice of medicine, even though it involves the exercise of administrative or managerial functions, where they are part of the day to day practice of a professional doctor. These functions include the matters identified in *Sadler* , such as proper record-keeping, adequate patient communication, proper courtesy shown to patients and so forth. Usually a failure adequately to perform these functions will fall within the scope of deficient performance rather than misconduct, but in a sufficiently grave case, where the negligence is gross, there is no reason in principle why a misconduct charge should not be sustained.

(4) Misconduct may also fall within the scope of a medical calling where it has no direct link with clinical practice at all. Meadow provides an example, where the activity in question was acting as an expert witness. It was an unusual case in the sense that Professor Meadow's error was to fail to recognise the limit of his skill and expertise. But he failed to do so in a context where he was being asked for his professional opinion as an expert paediatrician. Other examples may be someone who is involved in medical education or research when their medical skills are directly engaged.

(5) *Roylance* demonstrates that the obligation to take responsibility for the care of patients does not cease simply because a doctor is exercising managerial or administrative functions one step removed from direct patient care. Depending upon the nature of the duties being exercised, a continuing obligation to focus on patient care may co-exist with a range of distinct administrative duties, even where other doctors with a different specialty have primary responsibility for the patients concerned.

(6) Conduct falls into the second limb if it is dishonourable or disgraceful or attracts some kind of opprobrium; that fact may be sufficient to bring the profession of medicine into disrepute. It matters not whether such conduct is directly related to the exercise of professional skills.

(7) Deficient performance or incompetence, like misconduct falling within the first limb, may in principle arise from the

> inadequate performance of any function which is part of a medical calling. Which charge is appropriate depends on the gravity of the alleged incompetence. Incompetence falling short of gross negligence but which is still seriously deficient will fall under section 35C(2)(b) rather than (a).
>
> (8) Poor judgment could not of itself constitute gross negligence or negligence of a high degree but it may in an appropriate case, and particularly if exercised over a period of time, constitute seriously deficient performance.
>
> (9) Unlike the concept of misconduct, conduct unrelated to the profession of medicine could not amount to deficient performance putting fitness to practise in question. Even where deficient performance leads to a lack of confidence and trust in the medical profession, as it well might — not least in the eyes of those patients adversely affected by the incompetent doctor's treatment — this will not of itself suffice to justify a finding of gross misconduct. The conduct must be at least disreputable before it can fall into the second misconduct limb.
>
> (10) Accordingly, action taken in good faith and for legitimate reasons, however inefficient or ill-judged, is not capable of constituting misconduct within the meaning of section 35C(2)(a) merely because it might damage the reputation of the profession. Were that not the position then Professor Meadow would have been guilty of misconduct on this basis alone. But that was never how the case was treated.

The Decisions

23. Rule 4 Triage

i) On 26th September 2013 Tracy Fisher who was an Assistant Registrar employed by the defendant was considering the complaint against Sir Bruce Keogh at the rule 4 triage stage. She analysed the allegation against him and decided to seek advice from her senior colleague, Mr. Swain. He was Directorate Manager and Assistant Director of Investigations. Her evidence makes it clear that Assistant Registrars work as a team and that they consult each other about their work. She did this by email saying

> "I have spoken with Simon who is aware that we will be triaging the matter to him – but I would be grateful if you would please confirm if we are to triage this through the NIT route (due to the high profile/involvement of you and Paul Philip in the matter) or as a "normal" Stream 1 RIT [Regional Investigation Team] investigation with a request that it is allocated to Simon for investigation."

ii) This email, it is submitted, means that Ms. Fisher had decided that the complaint should not be rejected at the rule 4 triage stage and was asking for advice only on how it should be progressed thereafter.

iii) Mr. Swain responded

> "It's a stream 1 RIT case please.
>
> "My view is that we don't open a case on Sir Bruce on the Remedy point – i.e. he is too far removed from the point of care to be accountable on this issue in a regulatory sense. If you wanted cover for that view you could seek legal advice. If the legal adviser is to do anything other than close that aspect at triage, let me know before doing anything further."

iv) Tracy Fisher in her witness statement says that she did not regard this as a direction to her, merely as advice which she was entitled to consider. She included the advice she had received from Mr. Swain in her record, and recorded her decision as follows:-

> "In this case BL appears to be complaining that Professor Sir Bruce Keogh did not investigate concerns to his satisfaction. This is not normally a matter that would call into question his fitness to practise as a doctor or require a GMC investigation."

24. The Rule 12 stage

i) The decision letter is dated 13th October 2014 and is 7 pages long. It declines to review the rule 4 decision. It refers to the decision in *Remedy* and then says this

> "The Assistant Registrar is of the view that Professor Keogh could have taken a personal interest in this matter and it might have been better if more detailed explanation had been given why intervention was not within NHS England's remit. However, there is not any provision, of which we are aware, which compels him to do so in his role as Medical Director of NHS England. NHS England is not a complaint body and no concerns were identified at regional level by Dr. Mitchell. It would also not be possible for Professor Keogh to intervene in all situations such as this.
>
> Therefore the Assistant Registrar concluded that there were no concerns raised which would call into question Professor Keogh's fitness to practise and as a result there is no material flaw in the decision not to investigate the concerns."

25. It therefore follows that at both the rule 4 and the rule 12 stages the decision in *Remedy* was highly material to the outcome. The defendant had to grapple with the extent to which alleged failures in a management role could adversely impact on Sir Bruce's fitness to practise as a doctor.

26. The letter requesting a rule 12 review from Dr. Adam said this about Sir Bruce's role and responsibilities

> "I have worked in the equivalent role in the Department of Health, and understand the breadth of the responsibilities.
>
> "It was not necessary for Professor Keogh to be personally involved. It would have been sufficient for him to delegate the email to a colleague. He did not do this."

27. Paragraph 60 of Dr. Adam's witness statement which was prepared by Field Fisher and read by Tracy Fisher says

> "Finally, I understand the breadth of Bruce Keogh's responsibilities and the volume of work with which his office deals. However, I was concerned that he was not prepared to respond to documented failures to address potentially serious clinical concerns, especially as the email came from a senior and experienced former colleague, and in the context of NHS-wide concerns about failings in the quality of clinical care and failures of medical staff to escalate as necessary."

The Grounds of Challenge

28. In summary the complaint is that

i) Mr. Swain's intervention by his email of 26th September 2013 was unlawful (various other adjectives are also used in the Detailed Grounds). It is said that he took the decision outside the normal procedures of the GMC, and "overturned" a decision which had already been made.

ii) It is said that Mr. Swain's intervention was made on incomplete information as he only had an email from Ms. Fisher dated the 26th September 2013 to which he replied.

iii) It is said that the confusion over the identity of the complainant vitiated the decision. The Grounds say that the fact that Dr. Adam had made the complaint was "the single most important aspect of the complaint about Sir Bruce given her seniority and standing within the profession." Part of the material considered by Tracy Fisher was a long statement from Dr. Adam taken by Field Fisher. There is no evidence that Mr. Swain had read this and therefore he was not able to take her views into account.

iv) As to the rule 12 decision, it is submitted that the defendant asked the wrong question in assessing the strength or merits of the allegation rather than simply asking whether, if established, the allegation was capable of supporting a finding of misconduct or deficient professional performance. It is further said that the rule 12 decision was flawed because it failed to acknowledge that the interference of Mr. Swain had rendered the rule 4 decision flawed.

Discussion

29. In my judgment, this case resolves into two issues

    i) Was the intervention of Mr. Swain such as to render the rule 4 decision unlawful?

    ii) Was it rational to conclude that the role of Sir Bruce Keogh as Medical Director of NHS England was so remote from clinical care in the context out which the complaint arose that his failure to intervene was not capable of supporting a finding of misconduct or deficient professional performance? This was the decision on the merits at both the rule 4 and the rule 12 stage.

30. In my judgment, Mr. Swain's email does not support a conclusion that he, rather than Tracy Fisher, took the decision. She was entitled to reject advice or to accept it. Rule 4(4) makes it clear that she is not limited to the material supplied to her and can make investigations as necessary. It was clear from the suggestion by Mr. Swain that she may wish to take legal advice if she was in doubt about whether he was right that he was offering advice rather than an instruction. Whether to seek further advice was a decision which he left her to make. Plainly he knew that she was more familiar with the facts than he was, and so did she. He, as giver of advice, and she, as its recipient, both knew that if there was material available to her which showed he was wrong then it was her responsibility to appreciate and act on that fact.

31. I do not believe that the identity of the maker of the complaint was of critical importance. Ms. Fisher knew perfectly well that the complaint was supported by Dr. Adam because she had read her witness statement, see paragraph 27 above. The whole complaint was based on a failure to respond adequately or at all to two emails from Dr. Adam to Sir Bruce. Whether Mr. Swain knew this or not is beside the point because he was not, as I have found, the decision maker. Mr. Swain in fact knew about Dr. Adam's role in this complaint because he had met her on 10th October 2012 with Professor Levin, BL's father and Paul Philip, then the Director of Fitness to Practise. He thought she was assisting in facilitating BL's father to make a complaint, but he knew that she was involved. He did not know that it was she who had raised the issues with Sir Bruce Keogh.

32. Apart from the information in Dr. Adam's witness statement there was nothing to show that Professor Sir Bruce Keogh's formal role had any responsibility at all for the consequences of the complaints made by and on behalf of BL. There are processes within the NHS for addressing such things but no evidence was provided by Dr. Adam that Sir Bruce had any relevant responsibility as part of his job specification. Her evidence on that subject was very general and unpersuasive. It did not become any more cogent at the rule 12 stage, see paragraph 26 above. Mr. Swain's understanding of Sir Bruce's role is set out in a witness statement of 28th September 2015 at paragraph 8. It accords closely with that of the Assistant Registrar who conducted the rule 12 review which appears from the extract of his decision letter set out above.

33. For these reasons I conclude that there was no procedural flaw in the rule 4 decision and it was not irrational in its conclusion. In any event, any flaws which there were would be cured by a proper review under rule 12.

34. I reject the submission that the rule 12 decision was unlawful because it did not acknowledge the unlawfulness of Mr. Swain's involvement at the Rule 4 stage. First, I have held that his involvement was not unlawful. Secondly, and in any event, if Mr. Swain's conduct had amounted to a material flaw in the rule 4 decision that would trigger a review. That Assistant Registrar considered that no review was required because there was no material flaw in the decision on the merits. He concluded that the rule 4 decision was right and therefore lacking any material flaw. In relation to the complaint about the identity of the complainant, it is to be noted that that conclusion was reached after Dr. Adam had had an opportunity to submit any new material and after she had engaged in discussions with the GMC. By that stage it was very clear who was driving the complaint.

35. Therefore the sole remaining issue is whether the decision on the merits at the rule 12 stage was properly open to the Assistant Registrar who took it. The fact is that there is still no evidence to suggest that Sir Bruce Keogh has a responsibility for clinical care in any particular unit of any particular hospital. He cannot be responsible as a matter of professional misconduct for satisfactorily resolving (or even addressing) every problem which is communicated to him by email from anywhere in England. He could not do his job if he did not take the view that systems and procedures exist to resolve individual problems and that other senior people and bodies within the NHS have responsibilities for dealing with problems such as those raised with him by Dr. Adam. When he takes a decision about whether an issue is within his sphere of responsibility this is not a clinical decision arising out of his responsibility for the care of a patient or group of patients but a managerial decision.

36. Exactly the same reasoning applies to the strand of the claimant's argument which suggests that because lessons could be learned from BL's case which might be of relevance in treating other sufferers from Kawasaki Disease this brought it within Sir Bruce's responsibility as a doctor. I do not accept this and it is not based on any evidence. There are nearly always lessons which can be learned from mishaps, but that does not mean that Sir Bruce has a responsibility as a matter of professional conduct to attend personally to all mishaps of which he happens to learn. It is quite true that the clinical pathway for managing sufferers from that disease in London was apparently slow in being developed, but there is no evidence to show that this was any part of Sir Bruce's responsibility as a doctor. The issue was being managed by Dr. Mitchell, who did have a responsibility for NHS London. However senior Dr. Adam may have been within the NHS, she cannot impose professional obligations by sending emails. It would certainly have been better if Sir Bruce had responded personally and more patiently and if he had explained why BL's case was not his responsibility. That simple step might have avoided his involvement in these proceedings. However, discourtesy at least at that level is not capable of amounting to misconduct.

37. Stewart J, refusing permission in this case, after a full review of the papers, put the matter far more succinctly than I have been able to do. He said (speaking of the rule 4 decision) that it was for the Assistant Registrar to make. He said it was not arguably irrational. I agree. This applies equally to the rule 12 decision which was to the same effect.

38. I therefore refuse permission to pursue this judicial review claim.

APPENDIX: RULES 4, 8 AND 12 OF THE GENERAL MEDICAL COUNCIL (FITNESS TO PRACTISE) RULES 2004/2608

4.— Initial consideration and referral of allegations

(1) An allegation shall initially be considered by the Registrar.

(2) Subject to paragraphs (3) to (5) and rule 5, where the Registrar considers that the allegation falls within section 35C(2) of the Act, he shall refer the matter to a medical and a lay Case Examiner for consideration under rule 8.

(2A) Where the Registrar considers that an allegation does not fall within section 35C(2) of the Act the Registrar must notify the maker of the allegation (if any) accordingly.

(3) Where–

..

(b) in the case of an allegation falling within paragraph (5), the Registrar does not consider it to be in the public interest for the allegation to proceed; or

(c) the Registrar considers that an allegation should not proceed on grounds that it is vexatious,

he shall notify the practitioner and the maker of the allegation (if any) accordingly.

(4) The Registrar may, before deciding whether to refer an allegation, carry out any investigations as in his opinion are appropriate to the consideration of–

(a) whether or not the allegation falls within section 35C(2) of the Act;

(b) the practitioner's fitness to practise; or

(c) the matters outlined within paragraph (5) below.

(5) No allegation shall proceed further if, at the time it is first made or first comes to the attention of the General Council, more than five years have elapsed since the most recent events giving rise to the allegation, unless the Registrar considers that it is in the public interest, in the exceptional circumstances of the case, for it to proceed.

8.— Consideration by Case Examiners

(1) An allegation referred by the Registrar under rule 4(2), 5(2), 12(6)(b) or 28(3)(c) shall be considered by the Case Examiners.

(2) Upon consideration of an allegation, the Case Examiners may unanimously decide–

(a) that the allegation should not proceed further;

(b) to issue a warning to the practitioner in accordance with rule 11(2);

(c) to refer the allegation to the Committee under rule 11(3) for determination under rule 11(6); or

(d) to refer the allegation for determination by a FTP Panel.

(3) The Case Examiners may unanimously decide to recommend that the practitioner be invited to comply with undertakings in accordance with rule 10(3) and, where they do so and the practitioner confirms he is prepared to comply with such undertakings in accordance with rule 10(4), they shall make no decision under paragraph (2) accordingly.

(4) As soon as reasonably practicable, the Case Examiners shall inform the Registrar of their decision, together with the reasons for that decision, and the Registrar shall notify the practitioner and the maker of the allegation (if any), in writing, accordingly.

(5) If the Case Examiners fail to agree as to the disposal of an allegation under paragraph (2), or whether to recommend that the practitioner be invited to comply with undertakings under paragraph (3), they shall notify the Registrar accordingly, and the Registrar shall refer the allegation for consideration by the Committee under rule 9.

(6) If, at any stage, one of the Case Examiners is of the opinion that an Interim Orders Panel should consider making an interim order in relation to a practitioner, he shall direct the Registrar accordingly.

12.— Review of decisions

(1) Subject to paragraph (2), the following decisions may be reviewed by the Registrar–

(a) a decision not to refer an allegation to a medical and a lay Case Examiner or, for any other reason, that an allegation should not proceed beyond rule 4;

(b) a decision not to refer an allegation to the Committee or a FTP Panel;

(c) a decision to issue a warning in accordance with rule 11(2), (4) or (6); or

(d) a decision to cease consideration of an allegation upon receipt of undertakings from the practitioner in accordance with rule 10(4).

(2) The Registrar may review all or part of a decision specified in paragraph (1) on his own initiative or on the application of the practitioner, the maker of the allegation (if any) or any other person who, in the opinion of the Registrar, has an interest in the decision when the Registrar has reason to believe that—

(a) the decision may be materially flawed (for any reason) wholly or partly; or

(b) there is new information which may have led, wholly or partly, to a different decision,

but only if one or more of the grounds specified in paragraph (3) are also satisfied.

(3) Those grounds are that, in the opinion of the Registrar, a review is–

(a) necessary for the protection of the public;

(b) necessary for the prevention of injustice to the practitioner; or

(c) otherwise necessary in the public interest.

(4) The Registrar shall not, save in exceptional circumstances, commence a review of all or part of a decision specified in paragraph (1) more than two years after it was made.

(5) Where the Registrar decides to review all or part of a decision specified in paragraph (1), he shall in writing—

(a) notify the practitioner, the maker of the allegation (if any) and any other person who, in the opinion of the Registrar, has an interest in the decision of the decision to review and give reasons for that decision;

(b) notify the practitioner, the maker of the allegation (if any) and any other person who, in the opinion of the Registrar, has an interest in the decision of any new information and, where appropriate, provide them with that information; and

(c) seek representations from the practitioner, the maker of the allegation (if any) and any other person who, in the opinion of the Registrar, has an interest in the decision regarding the review of the decision,

and shall carry out any investigations which, in the opinion of the Registrar, are appropriate to facilitate the making of the decision under paragraph (6).

(6) Where the Registrar, taking account of all relevant material including that obtained under paragraph (5), concludes that all or part of a decision specified in paragraph (1) was materially flawed (for any reason) or that there is new information which would probably have led, wholly or partly, to a different decision and that a fresh decision is necessary on one or more of the grounds specified in paragraph (3), he may decide—

(a) to substitute for all or part of the original decision any decision which he could have made under Part 2 of these Rules; or

(b) that an allegation should be referred for reconsideration by the Case Examiners under rule 8, 10 or 11.

Otherwise, he must decide that the original decision should stand.

(7) Where the Registrar has reviewed all or part of a decision specified in paragraph (1), he shall notify–

(a) the practitioner;

(b) the maker of the allegation (if any); and

(c) any other person who, in the opinion of the Registrar, has an interest in receiving the notification,

in writing, as soon as reasonably practicable, of the decision under paragraph (6) and the reasons for that decision.