Neutral Citation Number: [2022] EWHC 1228 (Admin)

Case No: CO/413/2022

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

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 27th May 2022

Before:

MR JUSTICE EYRE

- -

Between:

PAUL HAWKER	**Appellant**
- and -	
THE HEALTH AND CARE PROFESSIONS COUNCIL	**Respondent**

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- -

Carolina Bracken (instructed by **Blackfords LLP**) for the **Appellant**
The Respondent did not appear and was not represented

Hearing date: 17th May 2022

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Approved Judgment

I direct that no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

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THE HON. MR JUSTICE EYRE

This judgment was handed down by the Judge remotely by circulation to the parties' representatives by email and release to The National Archives. The date and time for hand-down is deemed to be **10:00** on **27 May 2022**

Mr Justice Eyre:

Introduction

1. The Appellant was a registered paramedic working as such for the South Western Ambulance Service. By a decision of 6th January 2022 ("the Decision") the Health and Care Professions Tribunal Service ("the Panel") sitting as the Conduct and Competence Committee of the Health and Care Professions Council found that by reason of his actions on 24th October 2019 the Appellant's fitness to practise was impaired by reason of misconduct. It imposed the sanction of striking the Appellant's name from the Register.

2. In striking off the Appellant the Panel was exercising its powers pursuant to article 29(5) of the Health and Social Work Professions Order 2001. The Appellant advanced his appeal pursuant to article 29(9) of the Order on three grounds. First, it was said that the decision to impose the sanction of striking off was disproportionate. Second, it was said that the Panel had wrongly conflated lack of insight with a risk of repetition. Finally, it was said that the Panel had erred in treating as aggravating features matters which were already inherent in the finding of misconduct. In addition, before me it was said that the Panel had erred in its characterisation of the Appellant's failings on 24th October 2019 and that this error had pervaded the Decision.

3. The Respondent did not attend the hearing and had taken no part in the appeal process. However, Miss Bracken confirmed that her instructing solicitors had informed the Respondent of the appeal and in particular of the date of the hearing. Accordingly, I proceeded on the footing that the Respondent had chosen not to attend the hearing.

The Appellant's Career History.

4. The Appellant is now aged 57. He joined what was then the Dorset Ambulance Service in 1999. He became a registered paramedic in 2002 and subsequently became a specialist paramedic (formerly an Emergency Care Practitioner). It was common ground and accepted by the Panel that the Appellant had an unblemished career history and that there had been no other incidents of concern or which had called his fitness to practise into question.

The Incident on 24th October 2019.

5. It was common ground that at the end of his shift on 24th October 2019 the Appellant drove his ambulance onto the forecourt of the Sainsbury's Service Station in Weymouth in order to refuel the ambulance before returning to the Weymouth Ambulance Station. The Appellant was with a colleague and while the colleague was filling up the tank the Appellant walked towards the store in order to pay. As he was doing so the Appellant was told there were concerns about a person (identified by the Panel as Service User 1 or "SU1") in a car on the forecourt. The Appellant went towards the car. The CCTV footage of the scene showed that SU1 was in the driver's seat with the door open and with a female Sainsbury's employee (identified by the Panel as Witness 1 or "W1") standing alongside her. The Appellant and spent 48 seconds standing on the side of the door (i.e. nearer the car bonnet and with the door between him and SU1). He then left. SU1 was suffering a stroke. Police officers who were also on the forecourt to refuel their vehicle attended to SU1 after the Appellant had left. An ambulance was called but

because of the time it was taking for that to arrive the police officers themselves drove SU1 to hospital where she subsequently died. It was accepted that the Appellant's action had not contributed in any way to the death of SU1.

6. Beyond that common ground there was a dispute as to what the Appellant had been told and as to what he had said.

7. The Appellant's account was that he had been approached by a male member of the public who said, "I know you're off duty but there's a lady over there in a vehicle who's not feeling very well". He went across to the car where W1 was speaking to SU1. W1 told him that she thought that SU1 might have had a stroke. The Appellant then introduced himself to SU1 who looked well to him and whose presentation did not cause him any cause for concern. SU1 then replied "no" to his questions as to whether she needed any help, felt any pain, or wanted any further assistance or to go to hospital. He was then told by W1 that a phone call had been made for a relative to come and collect SU1 and that this was confirmed by SU1. He left having said to SU1 "OK that's fine if you don't need any help. But if for some reason in the future you need us call 999".

8. W1's account of the incident was markedly different in important respects. She said that her attention had been drawn to SU1 by a customer and that when she went to the car SU1 looked clammy and grey with her face drooping and with her speech becoming increasingly slurred. She thought that SU1 was having a stroke and it she asked her colleagues to call 999 for an ambulance. It was then that the Appellant and his colleague drove on to the forecourt. W1 said that she, rather than a customer, called the Appellant over saying that she thought SU1 was having a stroke and that a 999 call had been made but asking if there was anything which the Appellant could do to help. The Appellant came to the car and stood beside the bonnet. The Appellant did not, W1 said, speak to SU1 at all. Instead he looked towards his wrist saying, "we've finished now, we're clocking off, you'll have to continue with the 999 call". The Appellant then went into the store, paid for the fuel, returned straight to the ambulance, and drove off.

The Allegation against the Appellant.

9. The allegation against the Appellant was that his fitness to practise was impaired by reason of misconduct. That was put in these terms:

> "On 24 October 2019, whilst working on behalf of the South Western Ambulance Service, you did not act in the best interest of Service User 1 and/or adequately assess Service User 1 in that you:
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> a) did not adequately examine and/or assess Service User 1;
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> b) did not recognise that Service User 1 was experiencing the symptoms of a stroke;
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> c) did not complete an electronic patient clinical record (EPCR) for Service User 1;
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> d) did not ask Service User 1 to sign a refusal of treatment form."

10. Those actions were said to amount to misconduct and that misconduct was such as to impair the Appellant's fitness to practise. The Appellant admitted the contentions at (c) and (d) but denied misconduct or that there had been impairment of his fitness to practise.

The Material provided by the Appellant in respect of the relevant Sanction.

11. From 18th to 21st October 2021 the Panel heard evidence and submissions about the incident of 24th October 2019. Both the Appellant and W1 gave evidence and were cross-examined. In addition, the Panel were provided with stills from the CCTV footage and heard the evidence of two Ambulance Service employees who had viewed the footage. Having found the facts proved in the terms I will explain below it then moved, in December 2021 and January 2022, to consider whether the Appellant's actions constituted misconduct impairing his fitness to practise and to consider the sanction to be imposed. The Appellant did not give oral evidence at that stage. He did, however, provide a bundle of documentation in respect of impairment and sanction. This included a number character references speaking to his personal qualities but also to his performance as a paramedic. There were sundry certificates confirming the training he had undergone. In addition the Appellant provided a letter setting out something of his personal circumstances and commenting on the October 2019 incident together with a reflection deriving from having attended in October 2021 a patient undergoing a suspected cardio-vascular event; a further reflection derived from the day he had spent voluntarily shadowing staff at the Stroke Unit of a local hospital in November 2021 in order to improve his awareness of the presentation and treatment of cardio-vascular events and an academic review of thalamic cardio-vascular events.

The Decision.

12. The decision set out the three stages in the process undertaken by the Panel: the determination as to the facts; the conclusion in respect of whether there had been misconduct such as to impair the Appellant's fitness to practise; and finally the decision as to the appropriate sanction.

13. The Panel accepted the evidence of W1 which the members found to be clear and reliable. They were critical of the Appellant's evidence. They found him to be "inconsistent" in his giving of evidence and said that "much of his evidence was inherently implausible" and that it "lacked credibility". The Panel rejected the Appellant's account that his attention had first been drawn to SU1 by a male member of the public saying that it "concluded on the balance of probabilities that [the Appellant] had invented this encounter to explain how it was that W1 recalled him saying that he was unable to assist as he was off duty".

14. At [61] the Panel noted that the Appellant's own evidence had been that W1 had told him that she thought that SU1 had had a stroke. It found that what he went on to do thereafter was "wholly insufficient". As a consequence, it found allegation (a) proved concluding that the Appellant had failed adequately to examine or assess SU1. It also found allegation (b) proved saying, at [64] that the Appellant's failure to examine or assess SU1 meant that he did not discover the symptoms of a stroke and that it followed that he did not recognise the she was experiencing a stroke.

15. The Decision then addressed the question of misconduct and impairment of fitness to practise. As will be seen Miss Bracken criticised elements of the Panel's reasoning at this stage and its description of its findings. I will address those criticisms below but it is important to note at this point that the Panel's reasoning and the language used it to describe its findings are to be read in the light of the factual conclusions set out in the earlier part of the Decision and the acceptance of the evidence of W1.

16. At [75] the Decision said:

> "The Panel concluded that a member of the profession would regard the
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> Registrant's behaviour to be deplorable. His behaviour had fallen far below the standards expected of him as a registered Paramedic. He had
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> failed to conduct an assessment of a vulnerable member of the public,
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> despite significant concern expressed to him by another, engaged, member of the public. The Registrant had conceded in evidence that W1
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> had told him of her concern that SU1 was having a stroke. Despite this,
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> he had stood at SU1's car with her and W1 for a mere 48 seconds before
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> choosing to walk away. He conducted no assessment of SU1. He did not speak directly to her. His behaviour amounted to a flagrant disregard
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> of the needs of a member of the public in acute need. Instead, he had
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> chosen to leave SU1 in the care of W1 who was sufficiently concerned
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> to then engage the assistance of a passing police officer…"

17. At [76] the Decision quoted from part of the Appellant's evidence in which he had spoken of intuition and having a "sixth sense" of recognising when a patient was seriously unwell. The Panel treated this as part of the Appellant's explanation for why he had not carried out an examination of SU1. Miss. Bracken said that this was a misinterpretation of the evidence and that the Appellant's evidence had been as to how he carried out an examination when he did one. I reject this criticism. The Panel's interpretation of this aspect of the Appellant's evidence fits with the rest of the evidence as recorded in the Decision. Moreover, the context of the Appellant's evidence was the issue of his dealings with SU1. He was not giving evidence about his practice in general other than in the context of explaining what his interaction with SU1 was and why he did not take any further steps.

18. At [78] the Decision recorded the Panel's conclusion that the Appellant's behaviour on 21st October 2019 had amounted to misconduct. It turned to consider the question of impairment of his fitness to practise.

19. At [82] and [83] the Decision recorded that since the incident the Appellant had "taken steps to demonstrate why he should be allowed to continue in the profession" and that it was "clear" that he had "demonstrated remorse and regret". However, it then said, at [84]:

> "The difficulty faced by the Panel was that there was no evidence that [the Appellant's] fundamental attitude to the events on the day in question had altered."

20. The Decision noted a passage in the personal reflection provided by the Appellant and then said, at [86]:

> "It appeared from this passage, and from the flavour of his reflective statement as a whole, that whilst [the Appellant] now accepted that he did not spend long enough with SU1, he maintained the stance that he adopted in the course of the fact finding stage of these proceedings; that he had conducted some assessment of SU1, although did not "fully assess" her; and the reason for his lack of engagement was his "interpretation" that SU1 had refused his help, despite the contrary evidence from W1 that there had been no dialogue between them. Furthermore, [the Appellant]'s reflections did not demonstrate any acceptance on his part that the signs described by W1 at the time would have been clearly visible to him, just as they had been clearly visible to W1 and the police officers. [the Appellant] had left SU1 in the hands of W1, without conducting any assessment whatsoever. Whilst doing so, [the Appellant] would have been fully aware that preserving the welfare of any patient thought to be suffering a stroke would be time critical. He had refused to engage with W1, a significantly concerned and engaged member of the public, and SU1, a potentially seriously ill patient."

21. This passage and what were said to be the consequences flowing from it formed an important element of Miss Bracken's criticism of the Decision and I will consider that criticism below.

22. At [87] the Decision recorded that the Appellant had been given "ample opportunity… to explore whether the reality was that he had acted as he had done because he was at the end of a long shift" but that during his evidence he had said that this had not been a factor.

23. At [89] and [90] the Decision said:

> "89. Although [the Appellant] now accepted that he should have spent more time with SU1 and should have fully assessed her, he was unable to give the Panel a credible explanation for why he had chosen not to engage with SU1 or W1 as he should have done. …
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> 90. In this regard, there was nothing before the Panel to suggest that [the Appellant] now accepted his wrong-doing in walking away from SU1 and W1. Neither was there anything from [the Appellant] to demonstrate that he had addressed any factors that may have contributed towards him being unwilling to engage with SU1 and W1."

24. The Panel found the Appellant's fitness to practise impaired on the personal component with the following passage setting out the core basis of that finding:

> "92. Therefore in asking whether [the Appellant] had developed genuine insight into his misconduct, the Panel was driven to conclude that the attitude demonstrated by him in choosing not to engage with SU1 and W1, and voluntarily leave the scene, had not demonstrably altered.
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> 93. It was the judgement of the Panel that without these critical insights into his behaviour in relation to a patient presenting with potential serious ill health, there remains a risk of repetition of [the Appellant'] conduct. He therefore presents a risk to the public if permitted to practise unrestricted."

25. At [95] and [96] the Decision recorded the Panel's finding that in light of the public loss of confidence caused by his conduct the Appellant's fitness to practise was also impaired on the public component.

26. The Decision then addressed the question of the appropriate sanction noting that the purpose of the sanction was not to be punitive but to protect members of the public, to maintain proper standards within the profession, and to uphold the reputation of the profession and its regulator.

27. The mitigating factors were identified as being the Appellant's previous good character and unblemished career coupled with his continued work since October 2019 without further incident and the fact that he had shown regret and some remorse. At [108] the following were noted as aggravating factors:

> "• The seriousness of the incident
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> • The risk of harm to a highly vulnerable, elderly and acutely ill service user
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> • The Registrant's failure to heed the concerns expressed by W1
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> • The Registrant's recklessness and lack of compassion in leaving SU1 without having carried out any clinical assessment of her
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> • The Registrant's failure to raise concerns
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> • The Registrant's failure to work in partnership with his crewmate, Colleague 1, attending police officer or his colleagues in the Trust's control room.
>
> • The lack of relevant remediation or insight."

28. The Decision recorded the Panel's assessment that a Conditions of Practice Order would be insufficient sanction in these terms:

> "113. The Panel concluded that a Conditions of Practice Order would be insufficient in the light of the seriousness of the misconduct. The Panel had concluded that [the Appellant] lacked insight into his misconduct. Whilst the Panel had been informed that [the Appellant] now accepted the findings of the Panel, [the Appellant] had not evidenced any genuine understanding into the effect of his actions on SU1. Nor had he evidenced any understanding into the reputational damage to his profession with regard to his fellow professionals or the wider public. The material that he had put forward by way of suggested remediation had been misguided in that it focused on the competencies required to recognise the symptoms of a stroke when assessing a patient, rather than concentrating on his misconduct which the Panel had found proved. …
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> 114. Notwithstanding the above, the Panel noted that [the Appellant]'s competency in relation to his ability to recognise symptoms of a stroke had never been part of the allegations against him, rather it was his misconduct. This misconduct was attitudinal in nature in that the Registrant had deliberately and recklessly chosen to walk away from SU1 when he should have stayed to assess her. He had failed to examine or assess SU1 in order to form a view of her condition, or assist her in any way."

29. In considering each of the potential sanctions in ascending order of gravity the Decision had recited the relevant passage from the Defendant's Sanctions Policy. At [115] it recorded the following as being factors which would typically be exhibited in cases where a Suspension Order was likely to be appropriate:

> "- The concerns represent a serious breach of the standards of conduct performance and ethics
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> - The registrant has insight
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> - The issues are unlikely to be repeated
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> - There is evidence to suggest the registrant is likely to be able to resolve or remedy the failings."

30. At [116] – [118] the Decision said:

> "116. The Panel concluded that [the Appellant]'s misconduct represented a serious breach of the standards. He had not demonstrated insight and had not provided material to suggest that he was likely to be able to resolve or remedy his failings. It could not therefore be said that the misconduct was unlikely to be repeated.
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> 117. The Panel accepted that [the Appellant] had a long and unblemished career. He had continued in practice since the time of his misconduct some two years ago without further concern. He had provided good testimonials.
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> 118. However, [the Appellant] had chosen to walk away from a highly vulnerable and elderly member of the public in circumstances that he would have been aware were time critical and where there was considerable risk of serious harm. He had not provided evidence of relevant remediation. He had not shown insight into his misconduct. His decision to leave SU1 without professional assistance of any kind had been deliberate and reckless."

31. At [121] the Decision noted that the Panel had been asked to allow the Appellant more time to reflect on his actions. The Panel, however, declined to allow this noting that the Appellant had had a period of two years since the incident and two months since the Panel's findings of fact. It said that the Appellant had "not provided evidence of insight into his misconduct or any relevant remediation to address his attitudinal failings… Given the passage of time and the ample opportunity [the Appellant] has had to address his failings and provide evidence of such, the Panel could only conclude that [the Appellant] is unable to resolve or remedy his failings." That led to the following conclusion, at [122]:

> "The Panel concluded that without insight [the Appellant] continues to pose a risk to the public. The Panel also concluded that [the Appellant]'s actions adversely affected public confidence in him, in his Regulator and in his profession."

32. It was in the light of those conclusions that the Panel decided that the only appropriate order was the striking off of the Appellant saying, at [123], that the order was "necessary due to the seriousness of the misconduct and the lack of adequate remediation and insight."

The Approach to be taken to the Appeal.

33. The test I have to apply is whether the Decision was wrong. I am not bound by the conclusions reached by the Panel and must consider also whether the sanction imposed was appropriate and necessary or excessive and disproportionate. However, I must have in mind the weight to be attached to the specialist knowledge of the members of the

Panel as to the standards to be expected of registered paramedics; the relative gravity of the misconduct in question; and the level of sanction necessary to maintain public confidence in the profession. In addition, I must remember the benefit which the Panel had of seeing and hearing the evidence of the Appellant and the other witnesses. I derive those propositions from the decisions of the Privy Council in *Ghosh v General Medical Council* [2001] UKPC 29, [2001] 1 WLR 1915; of the Court of Appeal in *The Professional Standards Authority v The Health & Care Professions Council (Doree)* [2017] EWCA Civ 319; and of the Court of Appeal in *Bawa-Garba v General Medical Council* [2018] EWCA Civ 1879.

34. In *Ghosh* Lord Millett delivering the opinion of the Board said at [34]:

> "It is true that the Board's powers of intervention may be circumscribed by the circumstances in which they are invoked, particularly in the case of appeals against sentence. But their Lordships wish to emphasise that their powers are not as limited as may be suggested by some of the observations which have been made in the past. In *Evans v General Medical Council (unreported)* Appeal No 40 of 1984 at p. 3 the Board said:"
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> > "The principles upon which this Board acts in reviewing sentences passed by the Professional Conduct Committee are well settled. It has been said time and again that a disciplinary committee are the best possible people for weighing the seriousness of professional misconduct, and that the Board will be very slow to interfere with the exercise of the discretion of such a committee. … The Committee are familiar with the whole gradation of seriousness of the cases of various types which come before them and are peculiarly well qualified to say at what point on that gradation erasure becomes the appropriate sentence. This Board does not have that advantage nor can it have the same capacity for judging what measures are from time to time required for the purpose of maintaining professional standards."
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> "For these reasons the Board will accord an appropriate measure of respect to the judgment of the Committee whether the practitioner's failings amount to serious professional misconduct and on the measures necessary to maintain professional standards and provide adequate protection to the public. But the Board will not defer to the Committee's judgment more than is warranted by the circumstances. The Council conceded, and their Lordships accept, that it is open to them to consider all the matters raised by Dr Ghosh in her appeal; to decide whether the sanction of erasure was appropriate and necessary in the public interest or was excessive and disproportionate; and in the latter event either to substitute some other penalty or to remit the case to the Committee for reconsideration"

35. In *Doree* Lindblom LJ (with whom Sharp LJ agreed) said at [5] – [6]:

> "5. The relevant principles of law are well established. When a registrant appeals to the High Court against a decision of the Council, the court's function is to determine whether the Council's decision was wrong. In General Medical Council v Meadow [2007] Q.B. 462

> , Auld L.J. (in paragraph 197 of his judgment, with which Sir Anthony Clarke M.R. and Thorpe L.J. agreed) identified three factors which the court must have in mind and give appropriate weight: first, that "[the] body from whom the appeal lies is a specialist tribunal whose understanding of what the medical profession expects of its members in matters of medical practice deserves respect", second, that "[the] tribunal had the benefit, which the court normally does not, of hearing and seeing the witnesses on both sides", and third, that "[the] questions of primary and secondary fact and the overall value judgment to be made by a tribunal, especially the last, are akin to jury questions to which there may reasonably be different answers".”

> “6. The need for the court to exercise caution when reviewing a disciplinary tribunal's decision on sanction was emphasized by Laws L.J., with whom Chadwick L.J. and Sir Peter Gibson agreed, in *Raschid and Fatnani v General Medical Council [2007] 1 W.L.R. 1460* (in paragraphs 16 to 19 of his judgment Laws L.J. identified (in paragraph 16) two strands in the authorities preceding the change in the appeal system brought into effect in 2003. The first strand, he said, "differentiates the function of the panel or committee in imposing sanctions from that of a court imposing retributive punishment", and the second "emphasises the special expertise of the panel or committee to make the required judgment". He cited (in paragraph 17) the Privy Council's decision in *Gupta v General Medical Council [2002] 1 W.L.R. 1691* (see the judgment of Lord Rodger of Earlsferry, in which he referred, at paragraph 21, to the observation of Sir Thomas Bingham M.R., as he then was, in *Bolton v Law Society [1994] 1 W.L.R. 512* , at p.519, that "[the] reputation of the profession is more important than the fortunes of any individual member"). As to the second strand, Laws L.J. referred (in paragraph 18) to the decision of the Privy Council in *Marinovich v General Medical Council [2002] UKPC 36* , where Lord Hope of Craighead, giving the judgment of the Board, stressed (in paragraph 28) "… that the Professional Conduct Committee is the body which is best equipped to determine questions as to the sanction that should be imposed in the public interest for serious professional misconduct". Laws L.J. went on to say (in paragraph 19) that, as it seemed to him, "the fact that a principal purpose of the panel's jurisdiction in relation to sanctions is the preservation and maintenance of public confidence in the profession rather than the administration of retributive justice, particular force is given to the need to accord special respect to the judgment of the professional decision- making body in the shape of the panel".”

36. In *Bawa-Garba* delivering the judgment of the court Lord Burnett said that [94] – [96]:

> “94. As we said earlier in this judgment, the Tribunal was, in relation to all those matters and the carrying out of an evaluative judgement as to the appropriate sanction for maintaining public confidence in the profession, an expert panel, familiar with this type of adjudication and comprising a medical practitioner and two lay members, one of whom was legally qualified, all of whom were assisted by a legal assessor. As Lord Hope said in *Marinovich v General Medical Council [2002] UKPC 36:*”
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> > "28 …In the appellant's case the effect of the Committee's order is that his erasure is for life. But it has been said many times that the Professional Conduct Committee is the body which is best equipped to determine questions as to the sanction that should be imposed in the public interest for serious professional misconduct. This is because the assessment of the seriousness of the misconduct is essentially a matter for the Committee in the light of its

> experience. It is the body which is best qualified to judge what measures are required to maintain the standards and reputation of the profession."
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> "95. As Lord Wilson observed in *Khan* (at [36]), that is particularly true (as between the MPT and the courts) where the MPT's assessment of the effect on public confidence of misconduct relates to professional performance.
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> 96. We see no conflict between that approach and the observation of Collins J in *Giele v General Medical Council [2005] EWHC 2143 (Admin) [2006] 1 WLR 942* at [33] that public confidence in the profession must reflect the views of an informed and reasonable member of the public, or the statement of Holgate J in *Wallace v Secretary of State for Education [2017] EWHC 109 (Admin), [2017] PTSR 675* (at [92] and [96(v)]) that public confidence in the profession must be assessed by reference to the standard of "the ordinary intelligent citizen" who appreciates the seriousness of the proposed sanction, as well as the other issues involved in the case"

37. Considerable weight is to be attached to the judgement of a specialist tribunal as to the presence or absence of insight and as to the consequences of such presence or absence and those are "classically matters of fact and judgment for the professional disciplinary committee in the light of the evidence before it" (per Lindblom LJ in *Doree* at [38]). This is in part because of the opportunity which the panel will have had to assess the evidence of the professional in question. It is also because the specialist knowledge of the members of such a panel means that they will be best-placed to form an assessment of what is and what is not required for such insight to be present. Again, however, the court on an appeal is not bound by the findings of such a panel. Thus the court can conclude that a panel erred in automatically equating a denial of the allegations with an absence of insight or in concluding in the particular circumstances that an absence of insight indicated that there was a risk of repetition (see *R (Abrahaem) v General Medical Council* [2004] EWHC 279 (Admin) per Newman J at [39]; *R (Onwuelo v General Medical Council* [2006] EWHC 2739 (Admin) per Walker J at [33] – [36]; and *R (Vali) v General Optical Council* [2011] EWHC 310 (Admin) per Ouseley J at [46]) . Although such a denial is not conclusive as to the lack of insight it can be indicative of a lack of insight or can mean that the panel has no material from which it can find that the professional in question has the necessary insight. Much will depend on the facts of the particular case and on the evidence actually advanced in each case. The questions of the presence or absence of insight and of the risk of a repetition of the conduct in question are distinct. They are, however, closely connected and an absence of insight can be a potent indication that there is a risk of repetition (see per Collins J in *R (Bevan) v General Medical Council* [2005] EWHC 174 (Admin) at [37] – [39] expressing those points rather more succinctly).

Discussion and Conclusion.

38. As I have just indicated the Decision is to be read as a whole.

39. The third ground of appeal is that the list of aggravating factors set out at [108] of the Decision included matters which were already inherent in the findings of misconduct and impairment and that there was unfair double-counting in regarding them as

aggravating features when the Panel was considering the question of sanction. It is right that the matters listed were in large part matters which had already been considered and which had caused the Panel to reach its earlier conclusions. It is also right to note that the Appellant's failure to work with his colleagues had not featured in the allegation against him and was not something which had been addressed in the evidence. However, that was a minor feature which did not play any significant part in the final conclusion. Moreover, I am satisfied that when seen in the round the Panel's approach was not flawed by the alleged double-counting. It is apparent that in reality the factors were set out as aspects of the gravity of the Appellant's conduct. The Panel did not conduct an exercise akin to that of a judge sentencing for a crime of identifying a starting point and then considering factors which should cause a greater or lesser sentence to be imposed. Instead at [107] and [108] the Decision listed matters going into either side of the balance sheet when sanction was being considered. That was an entirely proper approach.

40. Next it was said that the Panel had been wrong to conclude, at [118], that the Appellant had chosen to walk way "in circumstances that he would have been aware were time critical and where there was considerable risk of serious harm". Miss Bracken said that this was an error in the light of the finding at [86] that the Appellant had "left SU1 in the hands of W1 without conducting any assessment whatsoever". It followed, Miss Bracken contended, that the Appellant was to be treated on the footing that he had not been aware that SU1 had suffered a stroke and was not to be treated as if he had walked away from a patient whom he knew had suffered a stroke. Miss Bracken said that the conclusion at [118] was crucial to the Panel's ultimate decision and that it had been based on a mischaracterisation of the Appellant's conduct: a mischaracterisation which she invited me to find pervaded the conclusion as to sanction more generally.

41. I do not accept that contention. Not only is the Decision to be read as a whole but it is to be noted that at [86] the Panel was not actually making a finding. The findings of fact had been recorded at an earlier stage in the Decision. Instead at [86] the Panel's reasoning in respect of impairment is being recorded and the words on which Miss Bracken relied are a paraphrase of the earlier findings which the Panel clearly had in mind. This is apparent from [114] where it is made clear that the gravamen of the Appellant's misconduct was choosing to walk away from SU1 without conducting an assessment.

42. Moreover, on the Appellant's own account he had been told by W1that she believed that SU1 was suffering a stroke. Even on the footing that the Appellant did not realise that SU1 was suffering a stroke because he did not assess her the position was that the Appellant was aware that a concern had been expressed that SU1 was so suffering and he chose to walk away notwithstanding awareness of that concern. It was not suggested that the Appellant was unaware that the treatment of strokes is time critical and that there was a considerable risk of harm. The difference between walking away from a patient who is suspected of having a stroke without undertaking an assessment and walking away having conducted an assessment in which the Appellant failed to recognise that the patient was suffering a stroke is of debateable materiality. It is certainly not a distinction of importance for the purposes of the Decision where it was clear from the Decision as a whole that the Panel were dealing with the Appellant for his conduct in walking away from SU1 after 48 seconds without conducting an assessment.

43. The Appellant mounted a sustained attack on the Panel's conclusions as to his level of insight and the risk of repetition of the misconduct. It is said that the Panel wrongly regarded the Appellant's dispute of the account as advanced by W1 as indicative of a lack of insight; that it erred in characterising the incident on 24th October 2019 as indicative of an attitudinal failing rather than an exceptional incident; and that because it conflated lack of insight with risk of repetition it wrongly concluded that there was a risk of repetition of such conduct. For the following reasons I reject those criticisms of the Decision.

44. The Appellant is correct to say that the questions of lack of insight and of the risk of repetition of the conduct in question are distinct questions. There can be circumstances, such as was accepted to be the position in *Bevan*, where it is no risk of recurrence notwithstanding an absence of insight. It is also possible to imagine circumstances, perhaps where a person has difficulty in controlling behaviour in respect of which he or she is fully insightful, in which there is a risk of repetition notwithstanding the presence of insight. Nonetheless, the questions of insight and the risk of repetition are closely related. The presence of lack of insight can be relevant, often highly relevant, to the question of whether there is a risk of repetition and in particular to an assessment of the degree of that risk. In *Bevan* Collins J explained that it was "implicit" that "insight is most material to ensure that the doctor [in that case] has realised that he has indeed gone wrong and therefore will not do anything similar in the future".

45. It is apparent that the Panel gave careful consideration to the question of whether the Appellant had demonstrated insight. The members of the Panel did not simply regard the Appellant's denial of the facts as alleged by W1 as conclusive of a lack of insight. They did take account of that denial as an element indicative of a lack of insight, but they were entitled to do so particularly in light of their findings as to his evidence. The Panel's findings at [50] as to the quality of the Appellant's evidence and at [58] as to the fabrication of an exchange with a male member of the public were robust findings but they were fully reasoned and were properly open to the Panel. The conclusions reached as to lack of insight are to be seen against the background of those findings and in those circumstances it was entirely legitimate for the members of the Panel to take the view that further material was needed if they were to accept that the Appellant had insight into his misconduct.

46. In any event the Panel's assessment of the presence or absence of insight went beyond consideration of the incident itself and of the Appellant's evidence about it. It is apparent that the Panel gave careful consideration to the events since the incident and in particular to the Appellant's actions in the interval between the Panel's findings of fact and the resumed hearing in respect of sanction. In that regard the conclusion set out at [113] and [114] of the Decision is of note and the Panel was entitled to conclude that a continuing lack of insight was demonstrated by the Appellant's attention to ways of recognising the signs of a stroke rather than to addressing the true gravamen of his misconduct in having walked away from SU1. It may be that the Appellant was unable to face up to the seriousness of what he had done or that he had convinced himself that his account was correct but the position remained that the Panel was entitled to conclude that there was a lack of insight and the conclusion in that regard cannot be faulted.

47. The Panel's finding as to a lack of insight was significant in two respects. First, in the particular circumstances of the incident of October 2019 and for the reasons just rehearsed the Panel was entitled to regard the Appellant's lack of insight as indicative

of a risk of repetition. In that regard the conclusions recited at [93] and [116] of the Decision cannot be faulted. Second, the absence of insight meant that one of the factors which the Sanctions Policy stated would normally be present for a Suspension Order to be appropriate was absent. The Panel was entitled to take that into account and to give it significant weight when deciding if such an order was appropriate.

48. It follows that the second ground of appeal fails.

49. I turn to the first ground of appeal namely that the sanction of the striking off of the Appellant was disproportionate. In considering whether the sanction was disproportionate the examples which Miss Bracken cited of the outcomes in other cases were of minimal assistance. *Bawa-Garba* and *Doree* were cases where there were unsuccessful appeals on the footing that the sanctions of suspension and a caution were too lenient and more severe penalties (erasure in the case of *Bawa-Garba*) should have been imposed. The fact that sanctions other than the equivalent of striking off were found not to be unduly lenient even for serious misconduct does not assist in assessing whether the sanction here was disproportionate. At the most the outcome in those cases is an indication that the Panel could have suspended the Appellant without the decision properly being characterised as being unduly lenient but that is different from the question I have to address of whether the sanction actually imposed was disproportionate. Similarly, it is little assistance that the particular facts of, for example, *Abrahaem* and *Onwuelo* sentences of erasure were found to have been disproportionate. The circumstances of each case and of each professional whose conduct is in question will be different and my task is to consider the sanction imposed on the Appellant in the particular circumstances of this case.

50. The striking off was undoubtedly a severe penalty in the light of the Appellant's otherwise blameless record; his return to work after his initial suspension by his employer and his continuation in work without further incident; and his remorse. However, the gravity of the Appellant's actions on 24th October 2019 must be borne in mind. The effect of the Panel's findings of fact was that the Appellant chose to walk away without assessing or assisting a person who was seriously unwell and about whom a member of the public was expressing concern rightly saying that she was suffering a stroke. The Appellant did so moreover on the basis that his shift had come to an end. In addition, regard must be had to the Panel's findings in respect of a lack of insight and a risk of repetition. My assessment is similar to that which Collins J reached in *Bevan*. There he was able to have regard to the effect of procedural failings which caused him exceptionally to allow the appeal but in the absence of such failings he would have refused the appeal on the footing that although severe the penalty was neither unreasonable nor disproportionate. Here, as there, the sanction was a severe one and it would have been open to the Panel to impose the lesser sanction of suspension. However, the conclusion that striking off was appropriate and necessary cannot be said to have been in any way unreasonable or outside the range of sanctions which could properly be imposed in these circumstances. In the light of the weight to be given to the specialist judgement of the Panel I am satisfied that the decision as to sanction although severe was not disproportionate. This ground of appeal also fails.

51. In those circumstances the appeal is dismissed.