PUBLIC RECORD

Dates: 11/04/2023 - 28/04/2023

Medical Practitioner's name:	Dr Jean MONRO
GMC reference number:	0552174
Primary medical qualification:	MRCS 1960 Royal College of Surgeons of England

Type of case	Outcome on facts	Outcome on impairment
New - Misconduct	Facts relevant to impairment found proved	Impaired

Summary of outcome

Suspension, 12 months.
Review hearing directed
Immediate order imposed

Tribunal:

Legally Qualified Chair	Ms Christina Moller
Lay Tribunal Member:	Ms Liz Daughters
Medical Tribunal Member:	Dr Joanne Topping

Tribunal Clerk:	Ms Jan Smith 17 and 24 April 2023 Ms Angela Carney 11 to 28 April 2023

Attendance and Representation:

Medical Practitioner:	Not present and not represented
Medical Practitioner's Representative:	N/A
GMC Representative:	Mr Christopher Hamlet, Counsel

Attendance of Press / Public

In accordance with Rule 41 of the General Medical Council (Fitness to Practise) Rules 2004 the hearing was held in public.

Overarching Objective

Throughout the decision making process the tribunal has borne in mind the statutory overarching objective as set out in s1 Medical Act 1983 (the 1983 Act) to protect, promote and maintain the health, safety and well-being of the public, to promote and maintain public confidence in the medical profession, and to promote and maintain proper professional standards and conduct for members of that profession.

Determination on Facts - 26/04/2023

Background

1. Dr Monro qualified as a doctor in 1960 and was practising as a General Physician, specialising in Environmental Medicine, at the time of events alleged below. Dr Monro was the Medical Director of Breakspear Medical ('Breakspear'), a private clinic.

2. The GMC allege that Dr Monro failed to provide good clinical care to Patient A, a 37-year-old woman, between May 2009 and January 2021. It is also alleged that Dr Monro failed to provide good clinical care to Patient B, a five-year-old boy, from March 2015 onwards. The alleged actions and omissions relate to issues of assessment, diagnosis, consent, treatment, safeguarding and referral.

The outcome of applications

3. On Day One [11/04/23] the Tribunal granted the GMC's application under Rules 20, 31 and 40 of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules') to proceed in Dr Monro's absence, after finding that the GMC had served notice of hearing on Dr Monro. Full reasons for the Tribunal's decision are at Annex A.

4. The GMC asked the Tribunal to consider Dr Monro's application for Voluntary Erasure ('VE') before evidence was heard. The Tribunal purported to refuse Dr Monro's application for VE but the GMC then said that this decision was *ultra vires,* or beyond the powers conferred on the Tribunal by statutory authority.

5. The GMC Registrar may only refer a VE application to a Tribunal for it to determine if the hearing has commenced: Regulation 3 of the GMC (Voluntary Erasure) Regulations 2004. Otherwise, the Tribunal does not have power to determine the application [under these Regulations: Statutory Instrument 2609 of 2004]. As the *ultra vires* determination made on Day Three [13/04/2023] was provided to Dr Monro, the Tribunal's full decision on the application is included at Annex B. Once it was confirmed that Dr Monro's application for VE had, most recently, been made on 24 February 2023 (***before*** this Tribunal hearing commenced on 11 April 2023) the application was correctly referred to Case Examiners, who decided on Day Five [17/04/2023] that the Allegation should proceed to a full hearing.

6. On Day Six [18/04/2023] the Tribunal refused the GMC's application to adduce the witness statement of Ms C, the mother of Patient B, made under Rule 34(1) of the Rules. Reasons for the Tribunal's decision are provided at Annex C. Then the Legally Qualified Chair (LQC) asked the GMC to make any application to amend the Allegation before oral evidence was given.

7. On Day Nine [21/04/2023] of the hearing, after all evidence had been heard, Mr Hamlet closed the GMC case and invited the Tribunal to consider amending the Allegation under Rule 17(6). The Tribunal did not amend the Allegation. The Tribunal's full decision and reasons are provided at Annex D.

The Allegation and the Doctor's Response

8. The Allegation against Dr Monro is set out below:

Patient A

1. Between 5 May 2009 and 25 January 2021 your care and treatment of Patient A was inadequate in that you:

a. inaccurately diagnosed her with:

i. sensitivity to electromagnetic radiation, including sunlight;
To be determined

ii. multichemical sensitivities;
To be determined

iii. multiple intolerances to food and fabric;
To be determined

b. inappropriately treated her with:

i. low dose immunotherapy;
To be determined

ii. micro dose of brussels sprout extract;
To be determined

c. failed to:

i. undertake any direct consultations with her after 2 June 2009, as doctor with overall care;
To be determined

ii. implement adequate measures to address her compromised communication and support needs;
To be determined

iii. obtain a second opinion from a gastroenterologist;

iv. make timely assessment of her mental capacity and / or examination of her physical well-being in light of her:

1. restricted lifestyle;
To be determined

2. deteriorating condition;
To be determined

d. maintained your diagnosis and treatment described in paragraph 1a. and 1b.i, despite your failure to undertake the actions described in paragraph 1c;
To be determined

e. failed to refer her care to the local NHS provider until January 2021.
To be determined

2. On or about 10 September 2020 upon learning about Patient A's attempt at self-harm on 30 August 2020, you failed to make a safeguarding referral for further management by:

a. her GP;
To be determined

b. the local district General NHS hospital.
To be determined

Patient B (a child)

3. From 30 March 2015 onwards your care and treatment of Patient B was inadequate in that you:

a. failed to communicate effectively with other health professionals involved in his ongoing care to ascertain:

i. which investigations had been carried out;
To be determined

ii. what treatment options had already been offered;
To be determined

iii. the treatment planned through the NHS;
To be determined

b. failed to:

i. develop a comprehensive care and management plan;
To be determined

ii. consider a differential diagnostic pathway;
To be determined

iii. assess any appropriate referrals required;
To be determined

iv. consider the possibility of Fabricated and Factitious Illness ('FFI');
To be determined

v. consider whether any safeguarding measures were required;
To be determined

c. made a referral for neurophysiological investigation using a Neuroscope device which:

i. was an experimental diagnostic tool;
To be determined

ii. was not clinically indicated for Patient B's presenting symptoms;
To be determined

iii. was an unconventional therapeutic approach that was inconsistent with current paediatric medical diagnoses and management;
To be determined

iv. was outside of a clinical trial;
To be determined

v. could not provide an identifiable treatment outcome;
To be determined

d. you supported therapeutic intervention which involved the wearing of an oxygen facemask for several hours a day:

i. which was experimental in nature;
To be determined

ii. which was of unproven benefit;
To be determined

iii. without undertaking the enquiries described in paragraph 3a;
To be determined

e. failed to obtain consent:
i. specific for investigation using the Neuroscope device;
To be determined

ii. using a modified consent form for use of the oxygen concentrator by a child;
To be determined

f. failed to work cooperatively with other healthcare agencies involved in his care to:

i. exchange information which could assist with the addressing of concerns relating to a possible FFI;
To be determined

ii. prevent harm through over-investigation and over-treatment;
To be determined

iii. consult about the treatment described in paragraphs 3c. and 3d. before it was offered;
To be determined

iv. contribute to multi-disciplinary review of care when safeguarding concerns over possible FFI were raised in mid-2015;
To be determined

v. have adequate regard to the concerns already raised about possible safeguarding concerns relating to Patient B's sibling;
To be determined

vi. undertake safeguarding interventions when sufficient concern about FFI became known in May 2017.
To be determined

And that by reason of the matters set out above your fitness to practise is impaired because of your misconduct.

The Facts to be Determined

9. Dr Monro did not admit any paragraph of the Allegation. The Tribunal was required to determine each paragraph of the Allegation.

Witness Statements

10. The GMC relied on written statements from the following witnesses, who did not give oral evidence:

- Dr D, Consultant Liaison Psychiatrist, Somerset NHS Foundation Trust: witness statement dated 26 October 2022
- Dr E, Autonomic Neurophysiologist, Queen Mary University London: witness statement dated 25 March 2019
- Dr F , Consultant Paediatrician, Stepping Hill Hospital: witness statement dated 4 April 2019
- Dr G, Consultant Paediatrician, Stepping Hill Hospital: witness statement dated 2 February 2019.

Expert Evidence

11. The GMC adduced reports prepared by two expert witnesses, who both gave oral evidence to the Tribunal:

- Dr H, Consultant in General Internal Medicine & Geriatric Medicine, report dated 5 January 2022.
- Dr I, Consultant General Paediatrician: report dated 17 January 2021 with a supplemental report dated 23 January 2021.

12. Dr Monro did not produce a witness statement herself or adduce written statements or oral evidence from anyone else. However, the GMC hearing bundles did include letters and other documents produced by Dr Monro.

Additional Documentary Evidence

13. The Tribunal considered documents provided by Dr Monro and the GMC, including:

- Patient A's medical records – Breakspear
- Patient A's medical records – Musgrove Hospital
- Patient B's medical records – Breakspear
- Breakspear *Safeguarding from Abuse Policy*
- NHS *Guidance on Multiple Chemical Sensitivity* (MCS)

- Royal College of Paediatrics *Guidance on Ethical Research involving Children*.

Advice from the Legally Qualified Chair (LQC)

14. At this stage the Tribunal is required to determine whether the facts alleged, or any of them, have been proved. The burden of proving disputed facts is on the GMC. Dr Monro does not need to disprove anything in the Allegation.

15. The standard of proof required is the civil standard, the balance of probabilities. Is the alleged fact more likely than not to have occurred? Where an event is inherently improbable, it may take better evidence to persuade a Tribunal that it has happened. This goes to the quality of evidence: *Byrne v GMC [2021] EWHC 2237*.

16. Hearsay may be given less weight than direct evidence as it has not been tested by question. The Tribunal should consider oral evidence in the context of documents.

17. The Tribunal must analyse the evidence fairly and impartially, taking account of any conflicts in evidence between witnesses or reasons why an allegation could not be true: *Khan v GMC [2021] EWHC 374*.

18. Although it cannot provide a defence, good character may be a factor capable of assisting Dr Monro. First, although she has not given evidence, there are emails, letters, clinical notes and other documents written by Dr Monro in the hearing bundles. The fact that Dr Monro has no cautions or convictions is a positive feature which the Tribunal may consider relevant when assessing the veracity of these documents.

19. Second, the fact that Dr Monro has no cautions or convictions may be considered relevant to the likelihood of her acting as alleged by the GMC. This must be subject also to the fact that a Warning was issued, in relation to similar issues, in 2012 by the GMC.

20. The Tribunal must consider the evidence in relation to each paragraph. If it finds one part of the Allegation proved, the Tribunal need not reach the same conclusion in relation to other parts. The Tribunal must be satisfied that each element of an allegation has been made out before finding it proved. It is for the Tribunal alone to determine whether, or not, the GMC has proved any part of the Allegation to the civil standard.

21. Counsel did not comment on the legal advice. The Tribunal took account of advice from the LQC in its approach to determining the Allegation.

The Tribunal's Analysis of Evidence and Findings of Fact

22. The Tribunal took account of oral and written submissions by Mr Hamlet, counsel for the GMC. Before drawing attention to relevant evidence in support of each paragraph of the Allegation, Mr Hamlet reminded the Tribunal of the role of expert witnesses:

'Expert evidence is there to assist the tribunal in understanding the technical aspects of the evidence. Unlike witnesses of fact, experts are entitled to provide an opinion on that evidence and the standard of care provided. They are not entitled to determine the charges themselves, which remain a matter for the tribunal. The tribunal can thus accept or reject the evidence of the experts, in whole or in part. Though if you do depart from the opinion of the expert, you are obliged to provide reasons. Where the experts have provided a view on matters that go directly to a charge in this case, you must take account of that view. However, you must draw your own conclusions on the evidence, having made your own assessment of the records, factual evidence and evidence from those experts.'

23. The Tribunal also took account of the written response to a draft Allegation from Weightmans LLP, Dr Munro's legal representatives, dated 20 February 2023. Although not a comprehensive response to the Allegation, it contained some potentially relevant points. The 'allegations of culpability' in relation to Dr Monro's care of adult Patient A were 'not admitted,' nor in relation to Patient B. On behalf of Dr Monro, Weightmans wrote that:

'The GMC proposes calling no evidence from Patient A and, having been informed that Patient A's partner refuses to co-operate, proposes to adduce a statement from him when he is not willing to attend and affirm the truth of his statement and answer questions from the Tribunal. In the absence of evidence about the events from witnesses able to give direct evidence, the GMC cannot prove to a proper standard the facts underlying the allegations in paragraph 1. The GMC cannot remedy that evidential deficiency by substituting the accounts given by the patient and then recorded in the notes at Musgrove Park Hospital in Taunton.

The GMC "expert" Dr H works in the NHS as a Consultant Geriatrician. Although his specialist registration is in General Internal Medicine and Geriatric Medicine, he declares no expertise in environmental medicine. He is not able to give properly informed evidence on the management of Patient A, who was aged around 37 at the material time, and consulted Dr Monro for expertise in environmental medicine.

The second set of allegations relate to the care of a child, now identified as Patient B. The GMC allege a number of failures 'from 30 March 2015'. No dates are attached to any of the failures then specified in the sub-paragraphs. There is no end point to the period of alleged failures. The allegations are deficient by reason of the lack of particularity. Further, the GMC alleges … failures relating to the treatment of Patient B by an independent medical practitioner when the GMC knows that its allegations against that practitioner failed and the investigation relating to his fitness to practise has been closed with no action… it is wrong and unfair to pursue Dr Monro with the allegations about that referral because the facts underlying the allegations now made against Dr Monro are those which you failed to prove against that practitioner.

Your expert, Dr I , is a Paediatrician and we note that he does not claim expertise in the use of a Neuroscope nor in Environmental Medicine, although on at least one occasion he purports to express an expert opinion on the standard to be expected of such a practitioner. His speculation that the referral and treatment by the independent practitioners who offered the challenged treatment would not have occurred is not a safe basis on which to reach a conclusion adverse to Dr Monro. It fails to take into account that a properly informed decision might well have sought advice from an expert in that treatment and concluded that it should be offered to the patient. It also appears, from the list of information referenced in his report, that he was not given information about the failed case against the independent practitioner who provided the Neuroscope investigation/treatment.

As the Tribunal is aware, Dr Monro will not be participating in the substantive hearing. However, in her absence the Tribunal would have to be astute to ensure that evidence is not received which is prejudicial and not relevant. Although we have not examined all the material proposed by the GMC it is notable, by way of example, that Dr G's statement includes much material that is not relevant and is prejudicial. Further, Dr I offers the opinion that a General Physician who takes on the care of a child they assume the responsibilities of a paediatrician and, it appears, should be judged by that standard. That cannot be right. By way of example, a General Practitioner treating a child does not take on those responsibilities and is not judged by that standard. In summary, Dr I is neither an appropriate expert, nor has he judged Dr Monro by the correct standards.

The overarching allegation that her fitness to practise as a medical practitioner is impaired to a degree warranting action on her registration is denied… The burden of proof remains on the GMC and the Tribunal will have in mind that it should not draw adverse inferences to support a conclusion that particular facts are proved because Dr Monro is not present and has not given evidence in rebuttal'

24. The Tribunal reminded itself that submissions by legal representatives on behalf of the GMC and Dr Monro do not constitute evidence. However, the Tribunal may consider all evidence in the context of Mr Hamlet's Closing on Facts and Weightmans' submissions.

Patient A

Paragraph 1a

1(a)(i) Between 5 May 2009 and 25 January 2021 your care and treatment of Patient A was inadequate in that you inaccurately diagnosed her with

(i) sensitivity to electromagnetic radiation, including sunlight;
(ii) multichemical sensitivities;
(iii)multiple intolerances to food and fabric;

Diagnosis by Dr Monro – Patient A

25. The Tribunal first considered whether Dr Monro had made one or more of the following diagnoses, listed at paragraph 1a, at any relevant time:

i. sensitivity to electromagnetic radiation, including sunlight
ii. multichemical sensitivities
iii. multiple intolerances to food and fabric.

26. The Tribunal considered that the GMC used the term '*electromagnetic radiation'* at paragraph 1(a)(i) to include *'sunlight'* but did not adduce evidence to establish that sunlight is one form of electromagnetic radiation. Mr Hamlet invited the Tribunal to infer that Dr Monro made a diagnosis of sensitivity to electromagnetic radiation, including sunlight, based on a reference in the Musgrove Hospital records to Patient A *'believing'* she was allergic to sunlight and electromagnetic fields. Although there was a reference to that belief by Dr D, there was no express reference to a diagnosis by Dr Monro.

27. In 2009 Dr Monro saw Patient A for the first and only time. In 2013 Dr Monro referred to having made a diagnosis of '*electrical sensitivity'* as a result of exposure to toxic dry-cleaning chemicals at work. There was no evidence that Dr Monro made a diagnosis of sensitivity to sunlight or electromagnetic radiation in relation to Patient A.
A leaflet entitled '*Electrical Sensitivity and the Environment*' was provided to Patient A which said: *'There may be electrical or acoustic frequencies. Eventually there may be a sensitivity to sunlight'.* The Tribunal did not consider it to be corroborative of paragraph 1(a)(i) of the Allegation.

28. The Tribunal did not conclude that Dr Monro had diagnosed 'sensitivity to electromagnetic radiation, including sunlight' based on an apparent belief by Patient A, who did not provide oral or written evidence.

29. The Tribunal took account of a letter dated 22 July 2013 from Dr Monro in support of Patient A's claim for industrial disability benefit due to the impact of MCS. Dr Monro wrote that Patient A *'is severely disabled due to multiple chemical sensitivities.'*

30. The Tribunal considered that the term 'multichemical sensitivities' could be used to describe Multiple Chemical Sensitivity (MCS). This is because MCS is described in various ways in clinical literature, such as NHS *'Policy Statement 36: Multiple Chemical Sensitivity (MCS) and Clinical Ecology/Environmental Medicine'* which says:

> *'MCS is also known as environmental illness, total allergy syndrome and idiopathic environmental intolerance (IEI). [These terms do not refer to a clinically defined disease and the relationship between exposures and symptoms is unproven].'*

31. Mr Hamlet asked the Tribunal to take account of a letter dated 1 September 2011 from NHS psychiatrist Dr J to Dr Munro: It referred to documents from Breakspear in relation to Dr Monro's assessment of Patient A on 5 May 2009 resulting in an opinion from

Dr Monro that [Patient A] '*had food and chemical sensitivities as a result of toxic volatile chemical exposure'*.

32. The Tribunal also took account of a letter dated 27 May 2010 from Dr S, Associate Physician, Environmental Medicine, Breakspear, which said:

> *'[Patient A] suffers from multiple chemical sensitivities, food sensitivities and probably react to electro magnetic fields.'*

33. Dr S and Dr Monro were colleagues at Breakspear, so the reference to MCS by Dr S adds to the likelihood that Dr Monro diagnosed Patient A with a condition amounting to MCS. Had the Tribunal considered multichemical sensitivity to be distinct from MCS, paragraph 1a(ii) would not be amenable to proof, without amendment to reflect evidence given.

34. It may plausibly be argued that Dr Monro diagnosed Patient A with 'multichemical sensitivities' in view of references in medical records to 'chemical sensitivities' indicating sensitivity to at least one substance. The term may be interpreted as referring to MCS, an acronym used by the NHS, despite an apparent controversy about possible causes, any mental health factors and treatment. The Tribunal concluded that Dr Monro had effectively diagnosed Patient A with 'multichemical sensitivities'.

35. The Tribunal took account of a letter about Patient A from Sheffield Social Care to Dr Monro dated 1 September 2011. It said:

> *'… any professionals assessing [Patient A] must present themselves with clothing that has only been washed in bicarbonate of soda, they are not wearing perfume or deodorant…'*

36. This indicates that Patient A, or someone else, requested visitors to minimise use of laundry liquid and other scented products. However, it does not support the assertion that Dr Monro diagnosed Patient A with an intolerance to any fabric itself. Although Dr H wrote that '*Dr Monro… diagnosed that Patient A was suffering from sensitivity to food, fabric and electromagnetic radiation,'* the Tribunal was not provided with clear evidence that Dr Monro diagnosed 'multiple intolerances to food and fabric' as claimed.
The Tribunal was provided with evidence of a diagnosis of multiple 'sensitivities' to food, but in the absence of a diagnosis of intolerance to fabric, this particular was not amenable to proof. The Tribunal interpreted the words in 1(a)(iii) as being conjunctive, not disjunctive.

37. The Tribunal found that Dr Monro had diagnosed Patient A with 'multichemical sensitivities' as alleged at paragraph 1a(ii). However, the evidence did not show that Dr Monro had made diagnoses of 'sensitivity to electromagnetic radiation, including sunlight' or 'multiple intolerances to food and fabric' as claimed at para 1a(i) and (iii).

Inaccuracy of diagnosis of 'multichemical sensitivities' or MCS

38. The Tribunal took account of a letter dated 22 January 2021 from Dr L , Locum Consultant Psychiatrist, Somerset NHS Foundation Trust to Dr M, Patient A's GP, which said:

> *'[Patient A's] difficulties started in 2008, she was chemically poisoned with PERC, which is a chemical used in dry cleaning and I was informed by Mr Y that this is a banned chemical. [Patient A] was working in dry cleaning at that time and the exposure initially resulted in headache but later went on to give her a range of physical health symptoms. She won claims as the company was deemed to be negligent. She is receiving compensation, £600 a month.'*

39. Dr L does not challenge Patient A's account of the catalyst for her symptoms.

40. Dr D, Consultant Liaison Psychiatrist, Somerset NHS Foundation Trust provided a witness statement dated 26 October 2022, also referring to compensation:

> *'Patient A described that, in 2008, she had suffered exposure to Perchloroethylene dry-cleaning fluid while working at a dry-cleaner's and had some reactions to these chemicals which adversely affected her health. Significantly, the owner of the dry-cleaning establishment was found negligent and Patient A was paid compensation for this exposure...'*

41. On 29 January 2021 a *'Consultation Summary – Mental Health Services'* report alludes to the fact that this dry-cleaning fluid, Perchloroethylene [referred to below as Pergathorine] is now 'banned':

> *'…[Patient A] told us that her symptoms first began in 2008 when she was exposed to Pergathorine (now banned substance) at a dry cleaning facility. She was exposed over a period of three months and started noticing symptoms including blood coming from her eyes, anus and mouth. Prior to this she reports that she was healthy and fit ... Reports to have a sensitivity to allergies, but says only mild. Her symptoms resulted in multiple hospital attendances and she was diagnosed with Multi Chemical Sensitivity.'*

42. The Tribunal took account of the fact that Patient A had been exposed in 2008 to a substance that had an impact so significant on her physical and/or mental health that the company responsible paid compensation. The chronicity of reported symptoms was such that Patient A was paid industrial disablement benefit. Whether reported symptoms are consequent to 'somatisation disorder' or based on physiological changes, a diagnosis of MCS may be justified. In 2013, the NHS recognised MCS as a condition potentially requiring care, according to *Policy Statement 36* cited above*:*

> '*Many experts have concluded that the basis of MCS is psychological rather than physical. Many MCS patients suffer from an emotional problem termed "somatisation disorder." This is characterized by persistent symptoMs Chat no known medical condition can fully explain but that may require medical treatment. Controversies*

about specific theories of MCS, diagnostic approaches or treatment modalities should not preclude the compassionate care of patients presenting with complaints consistent with MCS.'

43. In that context, the Tribunal found that the GMC had not discharged the burden on it to show that the diagnosis of MCS or 'multichemical sensitivities' was inaccurate.

44. When asked for his view of MCS as a diagnosis, Dr H told the Tribunal: *'It is moot, there is a lot of scepticism… the literature is equivocal… there is no concrete proof.'*
In answer to Tribunal questions he said that he does not believe MCS is ever an appropriate diagnosis.

'Q *Is it your view that MCS is never appropriate?*
A That is my view, but I cannot say for certain.'

45. The Tribunal was not persuaded by Dr H's opinion that this diagnosis was 'inaccurate' as alleged at paragraph 1(a). It took account of his openness about being uncertain.

46. The Tribunal considered that Dr H would regard any diagnosis of MCS as 'inaccurate' because he doubts its validity. As the term MCS is used by the NHS, the Tribunal was not persuaded by his view that MCS is never an appropriate, or accurate, diagnosis. It took account of Dr H's own acknowledgement that he could not '*say for certain'* and did not accept his opinion that *'…the diagnosis of multiple allergies and its treatment at Breakspear Medical Centre was inappropriate and inaccurate'* despite his account that '*at Musgrove Park hospital Patient A tolerated all kinds of food and stayed in normal environment without any negative repercussions.'*

47. Although Dr H referred to Patient A being able to tolerate food, he did not refer to Patient A tolerating exposure to chemicals in his report. He does not refute Patient A's account of being 'sensitive' to certain substances.

48. The Tribunal considered that Dr Munro had, at some point between 5 May 2009 and January 2021, made a diagnosis of multi chemical sensitivities in relation to Patient A, as alleged at paragraph 1(a)(ii) of the Allegation. The Tribunal interpreted the term 'multi chemical sensitivities' as synonymous with multiple chemical sensitivities (MSC).

49. The Tribunal was not provided with clear evidence of diagnoses of 'sensitivity to electromagnetic radiation, including sunlight' as alleged at paragraph 1(a)(i) or 'multiple intolerances to food and fabric' as alleged at paragraph 1(a)(iii).

50. The Tribunal determined that the GMC had not discharged the burden on it to prove that the diagnosis of 'multichemical sensitivities' was inaccurate as alleged at paragraph 1(a)(ii). Thus, the Tribunal found paragraph 1a not proved in its entirety.

Paragraph 1b

1b. Between 5 May 2009 and 25 January 2021 your care and treatment of Patient A was inadequate in that

(b) you inappropriately treated her with:

(i) low dose immunotherapy;

(ii) micro dose of brussels sprout extract.

51. Dr H's report indicated that 'low dose immunotherapy' included a 'micro dose of brussels sprout extract'. He asserted that Patient A '*was treated with low dose immunotherapy, which included injecting her with a micro dose of Brussels sprout extract.'* Therefore, the Tribunal considered paragraph 1b in its entirety.

52. The Tribunal read Dr Monro's letter to Patient A's GP, Dr M, on 30 July 2020:

> *'…She has been trying to include Brussel sprouts in her low-dose immunotherapy vaccines, which are attained by the neutralisation technique. She has been taking a sprouts end point and has a potato end point… [Patient A's husband] is trying to source organic Brussel sprouts to consume.'*

53. The Tribunal was provided with an explanatory leaflet from Breakspear Version 2.2 which said:

> *'Low dose immunotherapy*
> *The person is tested for their allergies with individual injections of the antigen as an injection under the skin (intradermally) or by using drops under the tongue (sublingually)… treatment vaccine is taken daily by injection, or two or three times daily when taken sublingually.'*

54. Although Brussels sprouts were not mentioned in a 'Cocktail' record sheet dated 28 November 2009 or an undated Vaccine list, taken from Patient A's medical records at Breakspear, the Tribunal was provided with a letter dated 4 August 2020 from Dr Monro to Dr M, alluding to '*low dose immunotherapy, attained by the neutralisation technique for…Brussels sprouts'*… and other foods.

55. When asked if low dose immunotherapy or a micro dose of Brussels sprout extract could cause harm, Dr H told the Tribunal that it may have a placebo effect but not cause harm, adding that this it is not his area of expertise. When Dr H was asked about the distinction between an allergy and a sensitivity, he claimed that the terms were '*used interchangeably'* but added that '*a sensitivity would not produce an allergic reaction.'* The Tribunal considered this discrepancy to reflect a lack of expertise in this area of medicine.

56. The Tribunal was not provided with cogent evidence that Dr Monro inappropriately treated Patient A with low dose immunotherapy and/or a micro dose of Brussels sprout extract. Although this was asserted by Dr H, the Tribunal was not provided with oral or documentary evidence of inappropriate low dose immunotherapy or micro dose of Brussels sprout extract.

Immunotherapy is a recognised treatment for allergies by the NHS and Dr H acknowledged that some of his colleagues used it. Medical records for Patient A did not show that immunotherapy was inappropriate.

57. The Tribunal was unable to make findings of fact in relation to the precise treatment given by Dr Monro or whether it was appropriate. No dates or other details were given. Dr H is a Consultant Geriatrician, without expertise in psychiatry or environmental medicine. The Tribunal was not persuaded by his evidence for the reasons given above.

58. The Tribunal concluded that the GMC had not discharged the burden on it to prove that Dr Munro inappropriately treated Patient A with low dose immunotherapy or with micro dose of Brussels sprout extract, as alleged.

59. The Tribunal found paragraph 1b not proved in its entirety.

1. Between 5 May 2009 and 25 January 2021 your care and treatment of Patient A was inadequate in that you

(c) failed to:

(i) to undertake any direct consultations with her after 2 June 2009, as doctor with overall care
(ii) implement adequate measures to address her compromised communication and support needs
(iii) obtain a second opinion from a gastroenterologist

60. In order to establish a failure by Dr Monro to undertake any direct consultations with Patient A, address particular needs or obtain a second opinion, the GMC would first have to demonstrate a duty to do so.

61. The Tribunal was provided with medical records indicating that Dr Monro had one direct consultation with Patient A at Breakspear in 2009. No medical records were provided in relation to Patient A's contact with her GP in Sheffield.

62. In relation to duty, the Tribunal considered whether there was evidence that Dr Monro had overall care of Patient A after 2 June 2009, as alleged at paragraph 1c.

63. Prescriptions were obtained by Patient A from Breakspear in 2011. Two years later Patient A completed a Breakspear change of details form.

64. On 8 March 2017 Dr N , Physician at Breakspear, makes a record of her consultation with Patient A. Dr Monro does not appear to be [directly] involved at this time, except as Medical Director.

65. In 2020 medical records suggest that Patient A is being seen as a 'new' patient. Private patients may have discrete episodes of treatment; this is different from permanent inclusion on a GP register, with only sporadic requests for treatment.

66. In order to prove any failure to consult directly, obtain a second opinion or take other steps to assist Patient A [after 2 June 2009] the GMC would have to establish that Dr Monro had a duty to provide care and treatment to Patient A. In the context of her GP and other clinicians being involved with Patient A, this has not been established.

67. The Tribunal took account of an email from Patient A to Dr Monro dated 16 October 2010. It indicates that Patient A was unwilling or unable to travel to Breakspear:

> '*…I cannot get in a car due to being so electrical sensitive so I cannot get anywhere…'*

68. The Tribunal also took account of a letter dated July 2014 from Dr Monro to Patient A in which she said: '*I would love to help you but you would have to attend an appointment first'.*

69. In view of Patient A's apparent refusal to travel to Breakspear, it would not have been feasible for Dr Monro to insist on a direct consultation. This is because Patient A was not compulsorily detained or deprived of liberty, so Dr Monro could not require her to have a consultation. However, Patient A was seen by clinicians at Breakspear on several occasions, including in 2009, 2017 and 2020.

70. In relation to mental health, the Tribunal took account of a letter dated 11 October 2011 from Dr O, Consultant Psychiatrist, Northern Sector Community Mental Health Team, to Patient A's GP. It refers to concerns of Dr P at Breakspear that:

> '*We are underestimating how [Patient A's] physical ramifications are dominating her present condition and that an improvement of her physical condition may well lead to improved mental health*'.

71. Dr O alludes to powers to detain patients under the Mental Health Act 1983, as well as the principle of using the least restrictive option. He suggests that *'another attempt at securing funding from the Primary Care Trust for a further stay for Patient A at Breakspear should be made*', implying that Dr O recognises a potential benefit to Patient A from treatment at Breakspear. This letter was copied to seven healthcare professionals, indicating that other clinicians were involved in Patient A's care.

72. The medical records indicate that Patient A was not 'sectioned' under the 1983 Act. At no point was Patient A deemed by any healthcare professional to lack capacity to make decisions about treatment or any other issue. In this context, the Tribunal did not consider that Dr Monro had a duty to 'implement adequate measures' to facilitate Patient A's ability to communicate. There was no evidence of Patient A having a 'compromised' ability to do so, in terms of cognition or mental state. If paragraph 1c(ii) refers to her reluctance to travel or use electronic devices, it is hard to see what Dr Monro could do about this.

73. Documentary evidence shows that Patient A saw other environmental physicians at Breakspear, as well as NHS clinicians between 5 May 2009 and 25 January 2021.

74. The Tribunal did not accept Dr H's assertion that a diagnosis of electro-magnetic sensitivity meant that Patient A had a compromised ability to communicate:

> *'I see no information available to Dr Monro [in medical records] regarding Patient A's particular communication and support needs. However, due to diagnosis of electro-magnetic sensitivity, Patient A's communication needs were compromised.'*

75. In oral evidence Dr H did not explain what he thought Dr Monro should have done to address Patient A's allegedly compromised ability to communicate or specify what was meant by 'support needs'. Breakspear and/or Dr Monro obtained consent from Patient A to liaise with her parents and partner in relation to healthcare when Patient A was having difficulties with travel, telephone or electronic devices.

76. Dr H did not explain why Dr Monro should obtain a second opinion from a gastroenterologist when Patient A '*tolerated all foods*' at Musgrove Park.

77. The Tribunal found that the GMC had not discharged the burden on it to prove that Dr Munro had a duty to undertake direct consultations with Patient A after 2 June 2009 as doctor with overall care, to implement adequate measures to address 'compromised' communication and support needs or obtain a second opinion from a gastroenterologist.

78. The Tribunal found paragraph 1(c)(i)(ii) and (iii) not proved.

Paragraph 1(c)(iv)(1) and (2)

1(c) Between 5 May 2009 and 25 January 2021 your care and treatment of Patient A was inadequate in that you

> *(iv) failed to make timely assessment of her mental capacity and / or examination of her physical well-being in light of her*
>
> 1. *restricted lifestyle;*
> 2. *deteriorating condition.*

79. There is a rebuttable presumption of capacity to make decisions about medical treatment and other issues in the Mental Capacity Act 2005. Patient A would be deemed to lack capacity in relation to a specific matter if, at the relevant time, she was unable to make a decision herself, due to an impairment of, or a disturbance in the functioning of her mind or brain. An unwise decision does not, in itself, indicate a lack of capacity.

80. Although Dr O's letter of 11 October 2011 indicates that Patient A was receiving care from North Sector Community Mental Health Team, it cannot be inferred from this that she lacked relevant decision-making capacity. As a psychiatrist Dr O could have assessed capacity if he thought it was required.

81. Patient A's GP, Dr M, requested an opinion from Somerset Psychiatric Team dated 15 January 2021 but gave his view that Patient A seemed to 'have capacity':

> *[Patient A] 'appears to have capacity in the decisions and see Patient A understand the severity of her symptoms but declines a health diet and treatment which would benefit her physical health...'*

82. Dr H gave oral evidence that a referral should have occurred 'early on' but did not explain why or when Dr Monro should have requested an assessment of capacity.

83. The Tribunal did not consider that it would be feasible for Dr Monro to conduct a physical examination of a patient who would not travel to Breakspear. However, the Tribunal also took account of evidence that Patient A was examined at Breakspear in 2017 and 2020, with follow up letters to her GP.

84. Other clinicians were involved with Patient A. In all the circumstances, the Tribunal did not consider that Dr Monro had a duty to assess mental capacity or conduct a physical examination of Patient A.

85. The Tribunal concluded that the GMC has not discharged the burden on it to prove that Dr Monro failed to make an assessment of Patient's A mental capacity and / or to conduct an examination of her physical well-being [for the reasons alleged].

86. The Tribunal found paragraph 1(c)(iv)(1) and (2) not proved.

Paragraph 1(d)

1(d) Between 5 May 2009 and 25 January 2021 your care and treatment of Patient A was inadequate in that you maintained your diagnosis and treatment described in paragraph 1a. and 1b.i, despite your failure to undertake the actions described in paragraph 1c;

87. The Tribunal found paragraphs 1a 1b and 1c not proved. Therefore paragraph 1(d) is not amenable to proof.

88. The Tribunal found paragraph 1(d) not proved.

Paragraph 1(e)

1(e) Between 5 May 2009 and 25 January 2021 your care and treatment of Patient A was inadequate in that you failed to refer her care to the local NHS provider until January 2021.

89. Patient A lived in Somerset and Breakspear was based in Hemel Hempstead. 'Local' is not defined in the Allegation, so could refer to local NHS providers in either locality.

90. In order to establish a failure to refer Patient A to a local NHS provider, the GMC would have to establish that Dr Munro had a duty to make such a referral.

91. As several clinicians were involved in Patient A's care, including a GP and other NHS clinicians, the Tribunal did not consider that the GMC had discharged the burden on it to show that Dr Monro had a duty to refer Patient A to a 'local' NHS provider. So the GMC was unable to establish any failure to do so.

92. Accordingly, the Tribunal found paragraph 1(e) not proved.

Paragraph 2

2. On or about 10 September 2020 on learning about Patient A's attempt at self-harm on 30 August 2020, you failed to make a safeguarding referral for further management by:
(a) her GP
(b) by the local district General NHS hospital.

93. The Tribunal also took account of evidence in medical records that Dr Monro was in contact with Patient A's husband and wrote letters informing her GP of relevant issues on 4 August 2020, 14 August 2020 and 18 August 2020.

94. The Tribunal considered an email dated 2 September 2020 to Dr Q , a Physician at Breakspear from Dr R, a Mental Health Counsellor, giving his view that Patient A was anxious and '*suicidal*'. The Tribunal was not provided with evidence that Dr Q alerted Dr Munro to Dr R concerns at this time.

95. On 10 September 2020 Patient A's husband mentioned, during a telephone call to Dr Munro, that Patient A had deliberately injured herself with a knife on 30 August 2020 but had been 'quite calm' since then. On the same day, 10 September 2020, Dr Munro wrote to Patient A's GP to report that Patient A had pierced two holes in her wrist.

96. On 23 September 2020 Dr Monro wrote to Dr S at Breakspear requesting an opinion in relation to Patient A's mental state. The Tribunal considered that Dr Monro had made efforts to involve other clinicians in Patient A's care

97. Although Dr H says in his report that *'There is no record to substantiate that any follow up action was taken by Dr Monro regarding [Patient A's] attempt to self-harm'* the Tribunal considered that Dr Monro had acted without delay, in a situation which did not appear to be an emergency, ten days after the self-injury.

98. In oral evidence Dr H did not identify any relevant GMC guidelines. The Tribunal did not accept his assertion that: '*Dr Monro should have reported the incident and made a follow-*

up plan. She should have contacted both the GP and the local district General NHS hospital for further management.' This is because Dr Monro did notify the GP and had no reason to contact a hospital. If the GP considered that an assessment was required under the Mental Health Act 1983 or the Mental Capacity Act 2005, the GP would arrange this. Otherwise, in a true emergency, it would make more sense to call 999 than to telephone a local hospital to tell someone about an incident of self-injury over a week earlier.

99. Breakspear's safeguarding policy defines a vulnerable adult:

'*A Vulnerable Adult is any person aged 18 years or over*

- *Who is or may be in need of community services because of mental or other illness, disability or age,*
- *Who is, or may be, unable to take care of themselves against significant harm or serious exploitation'.*

100. Breakspear's safeguarding flow chart indicates that clinicians may consider:

'Contact Adult Care Services at Hertfordshire County Council (referrals must be followed up in writing within 24 hours' or If there is a danger to life, a risk of injury or crime taking place, call the Police by dialling 999. '

101. It could be argued that Patient A was potentially vulnerable, despite not clearly satisfying any of the above criteria. However, there was no obvious reason to refer Patient A to Adult Care Services or call 999.

102. In order to establish a failure to make a safeguarding referral the GMC would have to establish that, after being informed on 10 September 2020, of Patient A's deliberate self-injury over a week earlier, Dr Munro had a duty to make a referral on or about 10 September 2020.

103. The Tribunal concluded the GMC had not discharged the burden on it to prove that Dr Munro failed to make a required safeguarding referral for further management by a GP or a local NHS hospital.

104. Accordingly, the Tribunal found paragraph 2 not proved in its entirety.

Patient B

Paragraph 3(a)

3. From 30 March 2015 onwards your care and treatment of Patient B was inadequate in that you:

a. failed to communicate effectively with other health professionals involved in his ongoing care to ascertain:

i. which investigations had been carried out;
ii. what treatment options had already been offered;
iii. the treatment planned through the NHS.

105. In order to establish a failure, the GMC would have to demonstrate that Dr Monro had a duty to communicate effectively with other health professional involved with Patient B. To determine the scope of any duty to communicate with other clinicians, the Tribunal considered evidence from Patient B's NHS consultant paediatrician, Dr G, as well as Dr I's expert opinion. Dr G Witness statement acknowledges that it is not common practice for private doctors to share records with health professionals in the NHS:

> '*Many of the consultations have been sought privately so neither I nor the family's GP will have any awareness of them as private medical records are not routinely shared with practitioners working in the NHS'*

106. The Tribunal also took account of Dr I's opinion that any clinician providing a second opinion on a child has a duty to liaise with other clinicians involved in their care. His expert report said:

> *'It is my opinion that any clinician who is providing a further opinion on any patient, especially a child, has a duty to liaise with clinicians that are already providing care. In Patient [B]'s case I would consider that there is a responsibility for Dr Monro to write to the paediatrician who is providing ongoing NHS care to both request information on treatment that had already been offered, as well as discovering what investigations had already been undertaken. I would also expect Dr Monro or the nutritional therapist to liaise with the dietician who was involved in the ongoing care of the patient.'*

107. Dr I expected a higher level of communication from private doctors treating a child than Dr G, who gave evidence about her experience of current practice, as opposed to best practice. As Dr G is an experienced paediatrician, the Tribunal accepted her account of the lack of communication between private and NHS doctors.

108. Nevertheless, the Tribunal had a copy of a letter from Dr Monro to Patient B's GP, Dr T, dated 29 April 2015. In this, Dr Monro provides a medical history, details of his examination, current symptoms, medication, diet and other interventions. Dr T would have been free to reciprocate, if consent to disclosure of confidential medical records had been provided by Patient B's parent/s. The Tribunal was not given evidence to indicate whether this was sought, refused or provided. In the absence of such consent, Dr Monro could not elicit information about NHS investigations or treatment.

109. Dr I's report says that Dr Monro:

> '*identified correctly that Patient [B] had already had endoscopy and colonoscopy and noted that he 'was found to have lymphoid hyperplasia and infiltration'. [Dr Monro]*

also noted that Patient [B] had been diagnosed to have 'small intestinal bacterial overgrowth and dysbiosis'. There was little attempt, however, in my opinion, to enquire about the complexity of investigation and management by other health professionals and current level of clinical involvement in his overall care plan, via the local paediatrician, which in my opinion was vital information to be able to develop a comprehensive care plan. For this reason, it is my opinion that Dr Monro took a medical history that was seriously below the standard expected of a doctor acting in the role of a General Physician.'

110. However, Dr G appeared to accept that private practitioners did not tend to liaise with NHS health professionals, except in an emergency. The fact that Dr Monro wrote to the GP involved suggests a willingness to communicate, as opposed to any failure to try to ascertain details of NHS investigations or treatment.

111. The Tribunal determined that the GMC had not discharged the burden on it to prove that, from 30 March 2015 onwards, Dr Monro's care or treatment of Patient B was inadequate due to a failure to communicate effectively with other health professionals involved in his ongoing care, to ascertain which investigations had been carried out and/or what treatment options had already been offered and/or the treatment planned through the NHS. Accordingly, the Tribunal found paragraph 3(a) not proved in its entirety.

Paragraph 3(b)

3. From 30 March 2015 onwards your care and treatment of Patient B was inadequate in that you:

b. failed to:

i. develop a comprehensive care and management plan;
ii. consider a differential diagnostic pathway;
iii. assess any appropriate referrals required;
iv. consider the possibility of Fabricated Factitious Illness ('FFI');
v. consider whether any safeguarding measures were required.

112. In order to establish a failure, the GMC would have to demonstrate that Dr Monro had a duty to develop a comprehensive care and management plan, consider a differential diagnostic pathway, assess any appropriate referrals required; consider the possibility of Fabricated Factitious Illness ('FFI') or whether any safeguarding measures were required.

To determine the range of any requisite care plan, the Tribunal considered Dr I's expert report:

'Without a broader differential diagnosis, it is difficult to assess what referrals would be appropriate and it appears to me that there was a reliance on the NHS paediatric services to make any other relevant referrals. The referral to the Nutritional Therapist was in keeping with the therapeutic intention ie a pattern of dietary challenge and immune modulation and presumably the intention was

that the Nutritional Therapist would liaise with other dietetic services involved in Patient [B's] care. I will address the referral to Dr J for investigation and treatment below.

…There was a lack of detail about the complexity of investigation and management within Patient [B]'s overall care plan to be able to make a reasonable management plan. For this reason, it is my opinion that Dr Monro took a medical history that was seriously below the standard expected of a doctor acting in the role of a General Physician (specialising in Environmental Medicine).'

113. The Tribunal had evidence that 'environmental medicine' was not a core part of mainstream NHS medicine. Patient B's mother asked Dr Monro to assess Patient B for 'an environmental perspective of his problems' from a doctor practising in that area. As Dr Monro was not a generalist and was never asked to provide a 'comprehensive care and management plan', the Tribunal did not consider that Dr Monro had a duty to provide this. Dr Monro's focus was on giving an environmental perspective, as requested by Patient B's mother. The Tribunal did not consider that Dr Monro had a duty to consider differential diagnoses, taking account of her limited role in the treatment of Patient B, who had a named Consultant Paediatrician in the NHS.

114. Dr Munro wrote to Dr T on 29 April 2015 and said that she recommended that Patient B see a nutritional therapist. This could be described as a referral, or at least an assessment of the need for a referral. Although Dr I's opinion was that '*there was a lack of consideration of other possible diagnoses for [Patient's B]'s symptoms*' and his report says that Dr Monro's investigations were '*largely focused on gastrointestinal and metabolic mechanisms related to presumed allergy*,' Dr I does not specify what other referrals should have been made by Dr Monro. The Tribunal did not consider that Dr Monro had a clear duty to make other referrals, in the context of GP involvement and input by a Consultant Paediatrician.

115. The Tribunal determined the GMC had not discharged the burden on it to prove that Dr Munro had failed to develop a comprehensive care and management plan, consider a differential diagnostic pathway, or assess any appropriate referrals required.

116. Accordingly, the Tribunal found paragraphs 3(b)(i), 3(b)(ii) and 3b(iii) not proved.

117. The Tribunal considered the issue of safeguarding to be connected to that of any diagnosis of FFI. Dr I's report said:

'*there were enough concerns about safeguarding issues from the time that [Patient B] was first seen by Dr Monro at Breakspear Medical which should have prompted an early discussion with the NHS Consultant Paediatrician. It is also my opinion that if that discussion had taken place, then it is unlikely that Patient [B] would have been subjected to neurophysiological assessment (Neuroscope) and would not have been given overnight oxygen which, I believe, was subsequently shown to be an unnecessary intervention.'*

118. The Tribunal did not consider that Dr Monro had a clear duty to consider Fabricated and Fictitious Illness (FFI). A Consultant Paediatrician had regular appointments with Patient B, who was also assessed by other NHS and private Consultants. However, Dr Monro was not apparently made aware of any suspicions of FFI.

119. Although his teachers and GP knew of safeguarding issues in relation to Patient B, no information appears to have been given to Breakspear Medical or Dr Monro. In the absence of warning signs or other evidence of FFI, the Tribunal considered that most doctors would trust a parent to be reporting potentially well-founded concerns about their child's health. Patient B's Consultant Paediatrician knew that he was attending Breakspear, as did his school, GP and other agencies involved in safeguarding discussions.

120. Without being alerted to concerns by any other professional, a clinician would not start by assuming or suspecting that a parent, or child, was inventing, or imagining, signs or symptoms. The Tribunal did not conclude that Dr Munro had a duty to consider FFI or safeguarding measures, as she was not alerted to these concerns about/by Patient B.

121. The Tribunal determined that the GMC had not discharged the burden on it to prove that Dr Munro had failed to consider the possibility of FFI, or whether any safeguarding measures were required, such that her care and treatment of Patient B was inadequate from 30 March 2015.

122. Accordingly, the Tribunal found paragraphs 3(b)(iv) and 3(b)(v) not proved.

Paragraph 3(c)

3. From 30 March 2015 onwards your care and treatment of Patient B was inadequate in that you:

c. made a referral for neurophysiological investigation using a Neuroscope device which:

i. was an experimental diagnostic tool;

ii. was not clinically indicated for Patient B's presenting symptoms;

iii. was an unconventional therapeutic approach inconsistent with current paediatric medical diagnoses and management;

iv. was outside of a clinical trial;

v. could not provide an identifiable treatment outcome.

123. Dr I consulted medical records at Breakspear and wrote in his expert report that Patient B was '*primarily under the care of Dr Monro'* who referred him to Dr J, Consultant Neurophysiologist, '*for a clinical autonomic assessment and some autonomic tests'* using a Neuroscope. Dr I said that Dr J '*provided Dr Monro with a written diagnosis/prognosis'* and recommended that Patient B would benefit from using '*an oxygen concentrator judging from the physiological results of the NeuroScope tests'*. Dr I gave evidence that, as Dr Monro was Medical Director of Breakspear at the time of Patient B's treatment, she was '*responsible for*

ensuring proper governance and assessment of patients.'

124. The Tribunal found that Dr Monro had referred Patient B to Dr J for neurophysiological investigation using a Neuroscope device, based on Dr I's written and oral evidence, as well as Dr Monro's acceptance that she was the first doctor at Breakspear to see Patient B.

> *'…It is my understanding that that the referral was for investigation, using a device called a Neuroscope, with which I am not personally familiar but which I understand to be a multi-channel recording of neurophysiological data. Since this, to my knowledge, is not routinely used in clinical practice, at least in children, (with the possible exception of children with Rett's syndrome), it is my opinion that this is an experimental tool and therefore its use to make diagnosis and inform management should be part of a clinical trial.'*

125. As an experienced Consultant Paediatrician, and Associate Medical Director, until recently at GOSH, Dr I was well-placed to give an opinion as to the adequacy of investigations on Patient B. The Tribunal took account of his evidence in relation to Dr Monro's responsibility as Medical Director for use of the Neuroscope and oxygen treatment at Breakspear. Dr I's report said that the Neuroscope device was an experimental diagnostic tool requiring approval for use in any trial involving children. By describing it as 'not routinely used' for children, Dr I's report indicated that use of the Neuroscope was an unconventional approach, inconsistent with paediatric diagnoses or management at the relevant time. His research led him to conclude that the Neuroscope was not clinically indicated, as Patient B did not have Rett's syndrome or seizures, nor was he considered to be on the autistic spectrum; he attended a mainstream school.

> *'The only references I can find on the use of the Neuroscope in children relate to its use in research into the physiology of seizure disorders (Edinburgh); Rett syndrome and autistic spectrum disorders. Since Patient [B] did not have any of these conditions, nor was being investigated for any of these, then I must assume that the use of this methodology was 'experimental'.*

126. The Tribunal considered that Dr Monro had a duty to provide adequate care and treatment to Patient B, both as a referring clinician and as Medical Director of Breakspear. Dr I described this in oral evidence as a 'dual' responsibility, adding that any clinician who recommends a course of investigation or treatment must take account of the needs of the child and their best interests; there was clear national and international guidance on the ethics of research involving children.

127. The Tribunal had no evidence that the use of the Neuroscope was in the context of a clinical trial. Breakspear clinical records do not provide evidence of informed consent being elicited from either parent of Patient B for him to participate in a clinical trial. Dr I said:

> *'Dr Monro had a duty of care to Patient [B] and a governance role within the Breakspear Clinic as its Medical Director; it is my opinion that the Neuroscope is an*

experimental tool when used in children and therefore its use to make diagnosis and inform management should be part of a clinical trial. It is my opinion that these diagnostic and treatment methods should only be used as part of a clinical trial; and, in failing to order such methods as a clinical trial, Dr Monro failed to ensure proper governance in Patient [B]'s care. In my opinion there was also failure to identify a treatment outcome (ie a measurable improvement) that would be required as part of an appropriately constituted clinical trial.'

128. The Tribunal accepted Dr I's opinion in relation to the Neuroscope. Although he was not familiar with it, the Tribunal considered that Dr I's lack of familiarity with its use could be explained by the fact that the Neuroscope was not in use in NHS paediatric services. The Tribunal determined that the GMC has discharged the burden on it to prove that, from 30 March 2015 onwards, Dr Monro's care and treatment of Patient B was inadequate
in that she made a referral for neurophysiological investigation using a Neuroscope device which was an experimental diagnostic tool, not clinically indicated for Patient B; this was an unconventional therapeutic approach, outside of any clinical trial, inconsistent with current paediatric medical diagnoses or management, with no treatment outcome identified.

129. Accordingly, the Tribunal found paragraph 3(c) proved in its entirety.

Paragraph 3(d)

3. From 30 March 2015 onwards your care and treatment of Patient B was inadequate in that you:

d. you supported therapeutic intervention which involved the wearing of an oxygen facemask for several hours a day:

i. which was experimental in nature;
ii. which was of unproven benefit;
iii. without undertaking the enquiries described in paragraph 3a.

130. Dr G was Consultant Paediatrician for Patient B at all relevant times and elicited information directly from the child: '*… the declaration by Patient [B] that he was receiving nightly oxygen treatment at home (in February 2017) evidenced that the concerning behaviours were ongoing*.' The Tribunal accepted Dr G's statement that Patient B was said to be '*using oxygen for four hours daily via face mask, from 7pm until [his] parents went to bed at 11pm*.' Although this evidence is hearsay, in that Dr G is reporting what Patient B and/or his mother said, the Tribunal accepted the veracity and accuracy of Dr G record of their conversations.

131. In oral evidence, Dr I told the Tribunal that '*the impact of a face mask on a child can cause physical and psychological harm'.* He said that Dr Monro was responsible for all '*modalities*' of treatment as safeguarding lead. Dr I's report said:

'It is my opinion that requiring a child below the age of five to wear an oxygen mask for several hours a day without evidence of chronic lung disease is both abusive and of unproven benefit. Therefore, for Dr Monro to support this therapeutic intervention, in my opinion, is seriously below the standard expected of a General Physician and Medical Director.'

132. Consultant Paediatrician, Dr F , said in her witness statement:

'I do not know if [Patient B's mother] was aware of the risks associated with Dr [J's] recommended treatment. However, there is increasing evidence of the potential harmful effects of oxygen and I would expect these risks to have been discussed. I have read Dr [J's] response to Dr G. I am not aware of a paediatric medical condition that arises as a result of poor oxygen delivery into peripheral tissues, in the presence of normal oxygen saturation. The possibility of it appeared to be speculation on Dr [J's] part.'

133. The Tribunal took account of evidence from Dr G, Consultant Paediatrician:

'I also discussed [Patient B] with [Dr U] who is one of the Paediatric Consultants in Metabolic Medicine at RMCH. She confirmed that none of their metabolic patients with proven mitochondrial disorders required home oxygen. She had no awareness of children with mitochondrial pathology ever needing treatment with oxygen. I wrote to the family on 6 March stating that [Patient B's] overnight oxygen saturation study was normal and that he did not need any additional oxygen therapy'.

134. On 29 March 2017 Dr J wrote to Dr G about Patient B in reply to her letter dated 6 March 2017. Dr J referred to a diagnosis of '*poor oxygen delivery into peripheral tissues*'. Dr J also alluded to his explanation, by telephone, saying that '*patients with poor oxygen delivery measured using the transcutaneous method delivery do have high oxygen saturation in the blood stream in the range of 98-100% saturation. We suspect that this is due to poor oxygen extraction at tissue level, but we do not have the scientific proof at present.'* The Tribunal inferred from this that Dr J accepted that the treatment was, to some extent, unproven or experimental.

135. Dr G provided evidence of the absence of any proven benefit [to Patient B] of use of an oxygen mask, in a statement taken by the police:

'Most recently [Patient B] has been reviewed by [Dr U] Consultant Paediatric Endocrinologist at RMCH, in clinic at parents' request. This was for a second opinion regarding [Patient B's] height, him having previously been seen by [Dr V] at RMCH. [Patient B] was seen on 2 March 2017with his mother. Subsequent to this appointment [Patient B] had blood tests to look at his full blood count and biochemistry and to check his thyroid and pituitary function; these tests were normal. Genetic tests to look for genetic causes of short stature were negative (normal). Some x-rays were taken which did not show any underlying problems with [Patient B's] bony skeleton. I discussed

[Patient B] with *[Dr U] via telephone in July. He felt that there was no indication for further testing and that the best approach now was conservative; that is to monitor [Patient B's] growth rate in clinic. He has been discharged by [Dr X] and I will do this in my outpatient clinic.'*

136. The Tribunal took account of evidence from Consultant Paediatricians indicating that the use of an oxygen mask for several hours a day had potential to cause physical and/or psychological harm to Patient B. As Medical Director of Breakspear, with a responsibility for safeguarding too, Dr Monro had a duty to ensure that no recommended treatment posed any risk to the patient/s. However, based on Dr I's analysis of clinical records from Breakspear and other evidence cited above, the Tribunal concluded that Dr Monro had supported Patient B's use of an oxygen mask for several hours a day, when this was experimental in nature and of unproven benefit, such that Dr Monro's care and treatment of Patient B was inadequate after 30 March 2015.

137. Accordingly, the Tribunal found paragraphs 3(d)(i) and 3(d)(ii) proved.

138. As the Tribunal found paragraph 3(a) not proved, paragraph 3(d)(iii) of the Allegation was not amenable to proof.

Paragraph 3(e)

3. From 30 March 2015 onwards your care and treatment of Patient B was inadequate in that you:

e. failed to obtain consent:

i. specific for investigation using the Neuroscope device;

ii. using a modified consent form for use of the oxygen concentrator by a child.

139. Although Dr I was critical of the consent process at Breakspear, in oral evidence, he said he was 'not sure' that Dr Monro had sufficient knowledge of the Neuroscope to elicit informed consent for its use. This would rest on being able to inform the parents, of Patient B, of potential risks, benefits and other options. Dr J would be better placed to obtain consent to use of the Neuroscope as he understood more about it. Therefore, Dr Monro did not have a duty to elicit informed consent.

140. As the Tribunal did not consider Dr Monro to have a duty to elicit informed consent from his parent/s for [Dr J's] use of the Neuroscope on Patient B, it determined that the GMC had not discharged the burden on it to prove a failure to obtain consent. Accordingly, the Tribunal found 3(e)(i) not proved.

141. The Tribunal considered the written statement of Dr J, Specialist Autonomic Neurophysiologist and Consultant Physician:

'I prescribed the use of an oxygen concentrator and re-assessment at scheduled intervals. The oxygen concentrator is not the same as a compressed medical oxygen cylinder as it simply removes nitrogen from the air supplied to the mask and is available without prescription in the free market. This was necessary to correct the tissue respiration abnormalities.'

142. The relevant Oxygen Concentrator consent form was signed by Dr E. Patient B's parent also signed this document, which said: *'I can contact Dr J or Dr E for advice …'* Dr Monro was not included here as a point of contact.

143. As Medical Director of Breakspear, Dr Monro should have had procedures in place to ensure that informed consent was obtained and recorded. However, the Tribunal did not consider that Dr Monro had a duty to obtain consent, herself, for use of an oxygen concentrator discussed with another clinician, Dr J who subsequently prescribed its use. Dr J had a clearer responsibility to obtain consent, if necessary, using a modified form for a child.

144. The GMC did not discharge the burden on it to establish that Dr Monro had a duty to obtain consent for use of the oxygen concentrator by Patient B. Accordingly, the Tribunal found 3(e)(ii) not proved.

Paragraph 3(f)

3. From 30 March 2015 onwards your care and treatment of Patient B was inadequate in that you

f) failed to work cooperatively with other healthcare agencies involved in his care to:

i. exchange information which could assist with the addressing of concerns relating to a possible FFI;

ii. prevent harm through over-investigation and over-treatment;

iii. consult about the treatment described in paragraphs 3c. and 3d. before it was offered;

iv. contribute to multi-disciplinary review of care when safeguarding concerns over possible FFI were raised in mid-2015;

v. have adequate regard to the concerns already raised about possible safeguarding concerns relating to Patient B's sibling;

vi. undertake safeguarding interventions when sufficient concern about FFI became known in May 2017.

145. Dr Monro is alleged to have failed to work cooperatively with other healthcare agencies involved in the care of Patient B at paragraph 3f. This is similar to the allegation that Dr Monro failed to communicate effectively with other health professionals: paragraph 3a.

146. The Tribunal has already found that Dr Monro did not have a duty to communicate with other health professionals in relation to a suspected FFI of which she was unaware.
The Tribunal did not consider that Dr Monro had an obligation to work with other healthcare agencies in this regard, or to prevent harm through over-investigation or over- treatment. This is

because Dr Monro did not have an overview of Patient B's contact with all health professionals, agencies, hospitals or other institutions. Similarly, Dr Monro was not made aware of safeguarding concerns in relation to Patient B's sibling. The Tribunal took account of Dr Monro's detailed letter to Dr T, Patient B's GP. Dr Monro appears to have been more open with other clinicians than they were with her or Breakspear.

147. The Tribunal considered Dr I's expert report:

> *'… It is my opinion that Dr Monro had a responsibility to liaise with Patient A's paediatrician who had expressed concerns about safeguarding with regard to this family. It is therefore my opinion that Dr Monro did not adequately consider any safeguarding issues for Patient A.'*

148. The Tribunal considered that Patient B should not have been investigated with the Neuroscope or asked to use an oxygen mask as described. However, the allegation that Dr Monro should have consulted others before using a treatment authorised by Breakspear at paragraph 3f(iii) appears to overlap with paragraph 3(d), as it is based on a similar factual nexus. In any event the Tribunal did not consider that Dr Monro had a duty to work cooperatively with other healthcare agencies involved with Patient B, taking account of the fact that there is no evidence that Dr Monro knew of safeguarding issues or suspected FFI.

149. Medical records indicated that a telephone call was made on 23 May 2017 by Patient B's grandmother to Breakspear about action taken in relation to suspected FFI. The GMC did not identify any concrete intervention that Dr Monro should have undertaken at this stage. The Tribunal had evidence that appropriate action had already been taken to safeguard Patient B.

150. The Tribunal was not persuaded by the argument that it should infer that Dr Monro was aware of discussions, in the absence of evidence of someone providing relevant information. Dr G suggested that private clinics did not usually provide records to the NHS, but the Tribunal was provided with evidence of Dr Monro's contact with Patient B's GP, Dr T , who had overall responsibility for his care and could have liaised with other agencies.

151. In all the circumstances, the Tribunal determined that the GMC had not discharged the burden on it to show that Dr Monro failed to work cooperatively with other healthcare agencies involved in Patient B's care, in relation to concerns about FFI, multi-disciplinary review of care, over-investigation or over-treatment with consequent harm to Patient B; nor in relation to proposed treatment advised by Breakspear, safeguarding of Patient B's sibling or interventions after FFI concerns were made known in May 2017.

152. Accordingly, the Tribunal found 3(f) not proved in its entirety.

The Tribunal's Overall Determination on the Facts

153. The Tribunal has determined the facts as follows:

1. Between 5 May 2009 and 25 January 2021 your care and treatment of Patient A was inadequate in that you:

a. inaccurately diagnosed her with:

i. sensitivity to electromagnetic radiation, including sunlight;
Not Proved

ii. multichemical sensitivities;
Not Proved

iii. multiple intolerances to food and fabric;
Not Proved

b. inappropriately treated her with:

i. low dose immunotherapy;
Not Proved

ii. micro dose of brussels sprout extract;
Not Proved

c. failed to:

i. undertake any direct consultations with her after 2 June 2009, as doctor with overall care;
Not Proved

ii. implement adequate measures to address her compromised communication and support needs;
Not Proved

iii. obtain a second opinion from a gastroenterologist;

iv. make timely assessment of her mental capacity and / or examination of her physical well-being in light of her:

1. restricted lifestyle;
Not Proved

2. deteriorating condition;
Not Proved

d. maintained your diagnosis and treatment described in paragraph 1a. and 1b.i, despite your failure to undertake the actions described in paragraph 1c;
Not Proved

e. failed to refer her care to the local NHS provider until January 2021.
Not Proved

2. On or about 10 September 2020 upon learning about Patient A's attempt at self-harm on 30 August 2020, you failed to make a safeguarding referral for further management by:

a. her GP;
Not Proved

b. the local district General NHS hospital.
Not Proved

Patient B (a child)

3. From 30 March 2015 onwards your care and treatment of Patient B was inadequate in that you:

a. failed to communicate effectively with other health professionals involved in his ongoing care to ascertain:

i. which investigations had been carried out;
Not Proved

ii. what treatment options had already been offered;
Not Proved

iii. the treatment planned through the NHS;
Not Proved

b. failed to:

i. develop a comprehensive care and management plan;
Not Proved

ii. consider a differential diagnostic pathway;
Not Proved

iii. assess any appropriate referrals required;
Not Proved

iv. consider the possibility of Fabricated and Factitious Illness ('FFI');
Not Proved

v. consider whether any safeguarding measures were required;
Not Proved

c. made a referral for neurophysiological investigation using a Neuroscope device which:

i. was an experimental diagnostic tool;
Determined and found proved

ii. was not clinically indicated for Patient B's presenting symptoms;
Determined and found proved

iii. was an unconventional therapeutic approach that was inconsistent with current paediatric medical diagnoses and management;
Determined and found proved

iv. was outside of a clinical trial;
Determined and found proved

v. could not provide an identifiable treatment outcome;
Determined and found proved

d. you supported therapeutic intervention which involved the wearing of an oxygen facemask for several hours a day:

i. which was experimental in nature;
Determined and found proved

ii. which was of unproven benefit;
Determined and found proved

iii. without undertaking the enquiries described in paragraph 3a;
Not Proved

e. failed to obtain consent:

i. specific for investigation using the Neuroscope device;
Not Proved

ii. using a modified consent form for use of the oxygen concentrator by a child;
Not Proved

f. failed to work cooperatively with other healthcare agencies involved in his care to:

i. exchange information which could assist with the addressing of concerns relating to a possible FFI;
Not Proved

ii. prevent harm through over-investigation and over-treatment;
Not Proved

iii. consult about the treatment described in paragraphs 3c. and 3d. before it was offered;
Not proved

iv. contribute to multi-disciplinary review of care when safeguarding concerns over possible FFI were raised in mid-2015;
Not Proved

v. have adequate regard to the concerns already raised about possible safeguarding concerns relating to Patient B's sibling;
Not Proved

vi. undertake safeguarding interventions when sufficient concern about FFI became known in May 2017.
Not Proved

Determination on Impairment - 27/04/2023

154. The Tribunal now has to decide in accordance with Rule 17(2)(l) of the Rules whether, on the basis of the facts found proved above, Dr Monro's fitness to practise is impaired by reason of misconduct.

The Evidence

155. The Tribunal considered oral and documentary evidence already produced.

Submissions

156. On behalf of the GMC, Mr Hamlet asked the Tribunal to take account of relevant principles in the following judgments: *Roylance v GMC [2000] AC 3111, Remedy UK v GMC [2010] EWHC 1245*, *Nandi v GMC [2004] EWHC 2317* and *Calhaem v GMC [2007] EWHC 2606* in relation to misconduct. Mr Hamlet submitted that Dr Monro's conduct fell significantly short of the standards expected of a registered medical practitioner; her actions amounted to misconduct.

157. Mr Hamlet asked the Tribunal to consider GMC guidance dated 22 April 2013, '*Guidance for Doctors - Delegation and referral*', paragraph 5 of which says:

> *'When you delegate care you are still responsible for the overall management of the patient.'*

158. Mr Hamlet submitted that Dr Monro should have known that Patient B had been subjected to unnecessary investigation and experimental treatment, with the potential to cause harm. There was no record of informed consent having been obtained from his parent/s for Patient B's participation in any clinical trial.

159. Mr Hamlet referred to paragraph 17 of *Good Medical Practice (GMP)* which provides:

> *'You must be satisfied that you have consent or other valid authority before you carry out any examination or investigation, provide treatment or involve patients or volunteers in teaching or research*.'

160. Mr Hamlet submitted that Dr I's description of Patient's B treatment as 'abusive' was relevant. When challenged about his treatment by Dr G, Dr J accepted that there was no scientific proof of efficacy or benefit, as Dr Monro should have been aware. Instead, Dr Monro had supported a treatment that had potential to cause serious harm to Patient B.

161. Mr Hamlet referred to paragraph 16 of GMP, which provides:

'16. In providing clinical care you must:
…
b. provide effective treatments based on the best available evidence.'

162. Mr Hamlet submitted that the Tribunal's findings of fact in relation to Dr Monro's care and treatment of Patient B amounted to misconduct in the context of professional practice.

163. In relation to impairment Mr Hamlet cited relevant principles in *Cohen v GMC [2008] EWHC 581, Zygmunt v GMC [2008] EWHC 2643, Cheatle v GMC 2009] EWHC 645 (Admin)* and *Grant v NMC* [2011] EWCH92.

164. Mr Hamlet submitted that Dr Monro's misconduct had placed a child at risk of physical and/or psychological harm. Despite Dr Monro's stated intention not to return to clinical practice, there would be a risk to patients if she did so.

165. By not making similar referrals for experimental treatment in future, the misconduct may appear to be remediable. However, Dr Monro's actions were at the core of her approach to environmental medicine.

166. Dr Monro has not engaged in these proceedings other than to seek Voluntary Erasure. Mr Hamlet submitted that Dr Monro has not taken any responsibility for her actions, so there remains a risk of repetition. Dr Monro's assertion that she will not return to clinical practice is the only thing that purports to address this risk.

167. Mr Hamlet submitted that a finding of impairment is required to uphold professional standards and maintain public confidence in doctors, even if the prospect of Dr Monro resuming clinical practice is considered to be remote.

The Relevant Legal Principles

168. The Legally Qualified Chair (LQC) gave legal advice on the approach for the Tribunal to take when considering impairment. Mr Hamlet made no comment on it.

169. In *Remedy UK v GMC* [2010] EWHC 1245 the High Court said that misconduct is of two principal kinds: first, misconduct going to fitness to practise in the exercise of professional medical practice**;** second, morally culpable or otherwise disgraceful conduct, outside or within professional practice. Conduct falls into the second category if it is dishonourable or attracts opprobrium; that fact may be sufficient to bring the profession of medicine into disrepute and it does not matter whether or not it is directly related to the exercise of professional skills.

170. In determining impairment the Tribunal considered principles in *Grant:*

'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:

a. has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or
b. has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or
c. has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession.

171. The Tribunal must determine whether Dr Monro's fitness to practise is impaired today, taking into account her conduct at the time of the events and any relevant factors since then such as whether the matters are remediable, have been remedied and any likelihood of repetition.

The Tribunal's Determination on Impairment

Misconduct

172. The Tribunal has found that Dr Monro's care and treatment of Patient B was inadequate, in relation to her referral for neurophysiological investigation using an experimental approach with a Neuroscope device which was not clinically indicated for Patient B's symptoms; this unconventional approach was inconsistent with paediatric practice at the time, it was provided outside of any clinical trial and Dr Monro did not identify any treatment outcome.

173. The Tribunal also found that Dr Monro supported an intervention which involved Patient B wearing an oxygen facemask for several hours a day; this was experimental in nature and of unproven benefit. The Tribunal accepted evidence from Consultant Paediatricians that the use of an oxygen mask for several hours a day had the potential to cause physical and/or psychological harm to Patient B.

174. In providing clinical care, a doctor must provide effective treatments based on the best available evidence according to paragraph 16 of GMP. However, Dr Monro did not do this and so did not follow relevant guidance.

175. The Tribunal accepted Dr I's evidence on the Neuroscope:

'I could find no letter of referral to Dr J for investigation using a device called a Neuroscope. It is my opinion that this is an experimental tool and therefore its use to make a diagnosis and inform management should be part of a clinical trial. It is therefore my opinion that the referral to Dr J was inappropriate and fell seriously below the standard expected of a consultant in Dr Monro's position.'

176. The Tribunal took account of paragraph 5 of the GMC's 2013 guidance on *'Delegation and referral'*, which provides that doctors are responsible for the overall management of their patients after delegating care.

177. The Tribunal considered that Dr Monro still had responsibility for Patient B's management after referring him to Dr J for investigation with a Neuroscope and subsequent experimental oxygen treatment.

178. The Tribunal took account of paragraph 49 of GMP:

> *'You must work in partnership with patients, sharing with them the information they will need to make decisions about their care, including:*
>
> *a. their condition, its likely progression and the options for treatment, including associated risks and uncertainties.'*

179. Dr I's gave evidence that Dr Monro had a duty of care to Patient B and a governance role within the Breakspear Clinic as its Medical Director.

180. The Tribunal took account of Dr I's opinion on the potential impact on Patient B of this treatment:

> *'… requiring a child below the age of five to wear an oxygen mask for several hours a day without evidence of chronic lung disease is both abusive and of unproven benefit. Therefore, for Dr Monro to support this therapeutic intervention, in my opinion, is seriously below the standard expected of a General Physician and Medical Director.'*

181. The Tribunal considered that this amounted to misconduct going to fitness to practise in the exercise of professional medical practice. It fell within the first of the two categories identified in *Remedy UK*. This is because Dr Monro's actions were unlikely to provide any benefit to Patient B and posed a risk of harm, such that other medical practitioners and members of the public would be likely to condemn them.

182. The Tribunal concluded that Dr Monro's actions in relation to Patient B fell so far short of the standards of conduct reasonably to be expected of a doctor as to amount to misconduct. Dr Monro's behaviour represented a significant departure from professional standards; her misconduct was serious.

Impairment

183. The Tribunal then considered whether Dr Monro's current fitness to practise is impaired by reason of misconduct. Dr Monro did not provide any evidence of regret or remorse for the actions and omissions found proved; nor was the Tribunal given any evidence of insight or remediation.

184. Dr Monro applied for Voluntary Erasure on the basis that she will not return to medical practice. However, the Tribunal had not heard from Dr Monro since the Case Examiners refused the application for VE.

185. The Tribunal took account of the fact that Dr Monro has relinquished her licence to practise, but she could seek to regain a licence. Although the Tribunal did not anticipate that Dr Monro would return to professional medical practice, this would be possible.

186. The Tribunal was not provided with evidence of actual harm to Patient B. However, it considered that Dr Monro's behaviour had placed Patient B at risk of harm when he was a young child. As Dr Monro is unlikely to return to medical practice, the Tribunal did not consider any future risk of harm to be high.

187. The Tribunal considered that Dr Monro's actions in 2015 had breached fundamental tenets of the medical profession. In addition, Dr Monro had brought the medical profession into disrepute and may do so in future if she were to resume practice.

188. The Tribunal concluded that it was necessary to make a finding of current impairment of fitness to practise in relation to Dr Monro's misconduct. Despite the passage of time, the public would not have confidence in medical professionals or in the regulatory system if the Tribunal regarded this sort of misconduct as leaving fitness to practise unimpaired.

189. The Tribunal considered Dr Monro's current fitness to practise to be impaired in the context of the absence of any evidence of insight or remediation. The Tribunal concluded that a finding of impaired fitness to practise was required to declare and uphold professional standards, as well as to maintain public confidence in the medical profession.

190. The Tribunal has therefore determined that Dr Monro's fitness to practise is impaired by reason of misconduct.

Determination on Sanction - 28/04/2023

191. Having determined that Dr Monro's fitness to practise is impaired by reason of misconduct, the Tribunal then had to decide, in accordance with Rule 17(2)(n) of the Rules on the appropriate sanction, if any, to impose.

The Evidence

192. The Tribunal considered all relevant evidence received at earlier stages.

Submissions

193. On behalf of the GMC, Mr Hamlet submitted that the only appropriate sanction was erasure. No other sanction would be sufficient to protect the public interest in all the circumstances, including the fact that the Tribunal found that Dr Monro's actions had posed a

risk of harm to Patient B, a five-year-old child who was vulnerable. The Tribunal should take account of its earlier reference to Dr Monro's significant departure from relevant guidance, as well as to serious misconduct, in its determination on Impairment.

194. Mr Hamlet did not identify any mitigating features, but submitted that there were significant aggravating features. Dr Monro provided the Tribunal with no evidence of regret or insight into the seriousness of the misconduct found. There was no reflection, acknowledgment of fault or attempted remediation.

195. Mr Hamlet invited the Tribunal to infer a lack of insight from the fact that this was never expressed by Dr Monro or her solicitors. Weightmans had sought Voluntary Erasure on behalf of Dr Monro, but not conveyed any regret or evidence of understanding of wrongdoing on her behalf to the GMC or this Tribunal.

196. Mr Hamlet submitted that the Tribunal should follow the *Sanctions Guidance*, published by the GMC / MPTS in November 2020 (the SG). Mr Hamlet submitted that there are no exceptional factors to justify taking no action. He said that conditions are not workable as Dr Monro said that she does not intend to return to clinical practice. Mr Hamlet also submitted that conditions would not be appropriate or sufficient to protect the public interest in this case.

197. Mr Hamlet also submitted that suspension would not be appropriate, in this case, or sufficient to protect the public interest, in the context of Dr Monro's lack of insight into the seriousness of her misconduct and potential risks to a child. As Dr Monro did not attend this hearing and the GMC has no up-to-date information. Mr Hamlet identified relevant guidance in paragraph 91 and paragraph 97 of the SG:

> *'91 Suspension has a deterrent effect and can be used to send out a signal to the doctor, the profession and public about what is regarded as behaviour unbefitting a registered doctor…*
>
> *97 Some or all of the following factors being present (this list is not exhaustive) would indicate suspension may be appropriate.*
>
> > *a. A serious breach of Good medical practice, but where the doctor's misconduct is not fundamentally incompatible with their continued registration, therefore complete removal from the medical register would not be in the public interest. However, the breach is serious enough that any sanction lower than a suspension would not be sufficient to protect the public or maintain confidence in doctors.*
> > *…*
> > *e. No evidence that demonstrates remediation is unlikely to be successful, eg because of previous unsuccessful attempts or a doctor's unwillingness to engage.*
> > *…*

g. The tribunal is satisfied the doctor has insight and does not pose a significant risk of repeating behaviour.'

198. Mr Hamlet added there is no evidence that Dr Monro would attempt remediation in the future, as there has been no engagement with this Tribunal hearing. He submitted that Dr Monro may attempt to return to medical practice. Dr Monro continued to work at the Breakspear well beyond normal retirement age, even after she had relinquished her licence to practice. In view of her apparent lack of insight, Mr Hamlet submitted that, if Dr Monro resumed practice as a doctor, there may be a high risk of repetition.

199. Mr Hamlet submitted that Dr Monro's misconduct is fundamentally incompatible with continued registration as a medical practitioner, in view of the lack of any evidence that remediation is likely to be successful. Dr Monro received a Warning from the GMC in 2012. Mr Hamlet relied on paragraph 108 of the SG:

'108. Erasure may be appropriate even where the doctor does not present a risk to patient safety, but where this action is necessary to maintain public confidence in the profession. For example, if a doctor has shown a blatant disregard for the safeguards designed to protect members of the public and maintain high standards within the profession that is incompatible with continued registration as a doctor.'

200. Mr Hamlet said that Dr Monro had shown a blatant disregard for safeguards designed to protect members of the public and submitted that her misconduct is fundamentally incompatible with continued registration as a medical practitioner, in the context of the absence of insight or remediation. Mr Hamlet cited paragraph 109 of SG:

'109. Any of the following factors being present may indicate erasure is appropriate (this list is not exhaustive).

a. A particularly serious departure from the principles set out in Good medical practice where the behaviour is fundamentally incompatible with being a doctor.
b. A deliberate or reckless disregard for the principles set out in Good medical practice and/or patient safety.
…
j Persistent lack of insight into the seriousness of their actions or the consequences.'

201. Although the Tribunal focused on past risk and did not identify a real risk of repetition, this was predicated on Dr Monro not resuming practice as a doctor. So the Tribunal may also take account of the real risk of repetition if Dr Monro were ever to resume medical practice. Mr Hamlet submitted that the only appropriate sanction is that of erasure. No other sanction would be sufficient to protect members of the public and the wider public interest.

Advice from LQC – approach by Tribunal

202. The Tribunal accepted advice from the LQC. There was no comment on it by counsel. At the Sanction stage of proceedings there is no burden or standard of proof; the decision on sanction is a matter for the Tribunal, taking account of the *SG* and *GMP,* as well as the statutory overarching objective. Where misconduct is grave or there has been a serious departure from professional standards, erasure may be the only means of protecting patients and of maintaining public confidence in the profession. The SG is intended to be flexible and is not specific comprehensive or specific in describing all circumstances. If the Tribunal departs from the SG it must give clear, substantial and specific reasons in its decision: *Bramhall* [2021] EWHC 2109.

203. Mitigation can affect the type of sanction, as well as the length of a relevant order. In *Wisniewska v NMC* 2016 EWHC 2672 it was said that, where there are only two options for sanction such as striking off or suspension, it is critical that the available mitigation is applied when evaluating the proportionality of a suspension as well as when considering erasure.

The Tribunal's Decision

204. The Tribunal considered that the main reason to impose a sanction is to protect the public and the wider public interest. Although a sanction is not imposed to punish a doctor, it may have a punitive effect. In its deliberations, the Tribunal applied the SG principle of proportionality, balancing Dr Monro's interests with the public interest, including the need to maintain confidence in the medical profession, uphold standards and protect members of the public.

205. The Tribunal has already given a detailed determination on impairment, and it has taken those matters into account during its deliberations on sanction.

<u>Aggravating and Mitigating Factors</u>

206. The Tribunal took account of its decisions at earlier stages of this hearing, in its deliberations on sanction. The Tribunal considered and balanced the aggravating and mitigating factors identified in this case. The Tribunal took account of paragraph 25 of the SG:

> *'25. The following are examples of mitigating factors.*
> *…*
> *e. Lapse of time since an incident occurred*.'

207. The Tribunal identified the lapse of time, of several years, as a mitigating factor. No other issue was presented as a mitigating factor by Dr Monro.

208. The Tribunal considered paragraph 52 of the SG to be relevant:

'A doctor is likely to lack insight if they:

a) refuse to apologise or accept their mistakes

….

c) do not demonstrate the timely development of insight

209. The Tribunal considered the fact that Dr Monro has not provided any evidence of regret, apology, remediation or insight into risks posed by her misconduct to be an aggravating factor. There was no reflective statement or other indication that Dr Monro had thought about the impact on Patient B of the referral to Dr J for investigation with a Neuroscope and treatment, requiring him to wear an oxygen mask for several hours a day. Any private acknowledgement of fault was not communicated to the Tribunal.

No action

210. The Tribunal first considered whether to conclude the case by taking no action.

211. In view of the seriousness of Dr Monro's misconduct, the Tribunal considered that it would not be in the public interest to take no action, as this would not uphold standards or maintain public confidence in the medical profession.

212. The Tribunal considered that there were no exceptional circumstances that would justify taking no action in relation to Dr Monro's registration.

Undertakings

213. Undertakings were not offered or agreed by Dr Monro or the GMC.

Conditions

214. The Tribunal next considered whether to impose conditions on Dr Monro's registration. Any conditions need to be appropriate, proportionate and workable.

215. The Tribunal; took account of paragraph 82:

'82. Conditions are likely to be workable where:

a. the doctor has insight
b. a period of retraining and/or supervision is likely to be the most appropriate way of addressing any findings
c. the tribunal is satisfied the doctor will comply with them
d. the doctor has the potential to respond positively to remediation, or retraining, or to their work being supervised.'

216. The Tribunal did not consider that Dr Monro had shown insight, nor that she would comply with conditions. This is because Dr Monro did not provide oral or written evidence demonstrating that she has insight or would comply with conditions.

217. The Tribunal did not consider that a conditions of practice order would be appropriate or sufficient to uphold standards or to maintain public confidence in the medical profession.

218. The Tribunal decided not to impose conditions on Dr Monro's registration.

Suspension

219. The Tribunal then went on to consider a suspension order. It took account of the fact that suspension may have a deterrent effect, and indicate to doctors, as well as the public, the standards expected of registered medical practitioners. The Tribunal also took account of the absence of any acknowledgement of fault.

220. The Tribunal considered the following paragraphs of the SG:

> *'91. Suspension has a deterrent effect and can be used to send out a signal to the doctor, the profession and public about what is regarded as behaviour unbefitting a registered doctor. Suspension from the medical register also has a punitive effect, in that it prevents the doctor from practising (and therefore from earning a living as a doctor) during the suspension, although this is not its intention.*
>
> *92 Suspension will be an appropriate response to misconduct that is so serious that action must be taken to protect members of the public and maintain public confidence in the profession. A period of suspension will be appropriate for conduct that is serious but falls short of being fundamentally incompatible with continued registration (ie for which erasure is more likely to be the appropriate sanction because the tribunal considers that the doctor should not practise again either for public safety reasons or to protect the reputation of the profession).*
>
> *93 Suspension may be appropriate, for example, where there may have been acknowledgement of fault and where the tribunal is satisfied that the behaviour or incident is unlikely to be repeated. The tribunal may wish to see evidence that the doctor has taken steps to mitigate their actions (see paragraphs 24–49).*
>
> *95 In such cases, to protect the public, the tribunal might wish to impose a period of suspension. The suspension will need to be reviewed and therefore a review hearing should be directed. Such a direction should indicate in broad terMs Che type of action and evidence of remediation… which, if carried out… may help the tribunal's evaluation at any subsequent review hearing.'*

221. The Tribunal took account of paragraph 97:

> *'97 Some or all of the following factors being present (this list is not exhaustive) would indicate suspension may be appropriate.*
>
> > *a. A serious breach of Good medical practice, but where the doctor's misconduct is not fundamentally incompatible with their continued registration, therefore complete removal from the medical register would not be in the public interest. However, the breach is serious enough that any sanction lower than a suspension would not be sufficient to protect the public or maintain confidence in doctors.*
> > *…*
> > *e. No evidence that demonstrates remediation is unlikely to be successful, eg because of previous unsuccessful attempts or a doctor's unwillingness to engage.*
> > *…*
> > *g. The tribunal is satisfied the doctor has insight and does not pose a significant risk of repeating behaviour.'*

222. The Tribunal concluded that Dr Monro's behaviour amounted to a particularly serious departure from the principles in *GMP* and other relevant guidance. Although Dr Monro did not provide evidence of insight into the gravity of her actions or potential risks, she did not seek to justify them. The Tribunal took account of the lapse of time, as well as the apparent lack of remorse or remediation. It was important to apply the principle of proportionality in balancing the relevant factors. Although Dr Monro's misconduct was serious, the Tribunal did not consider it, in all the circumstances, to be fundamentally incompatible with continued registration.

223. The Tribunal considered that Dr Monro's behaviour had posed a risk to Patient B. However, it did not consider any future risk of harm to be high, because Dr Monro is unlikely to return to practice, as she is now aged 86. In 2021 Dr Monro relinquished her licence to practise. The Tribunal determined that a suspension order would be appropriate and sufficient to declare and uphold standards, as well as to maintain public confidence in the medical profession.

224. In deciding the period of suspension the Tribunal considered the following paragraphs of the SG:

> *'99. The length of the suspension may be up to 12 months and is a matter for the tribunal's discretion, depending on the seriousness of the particular case.*
>
> *100. The following factors will be relevant when determining the length of suspension:*
>
> > *a. the risk to patient safety/public protection*

b. the seriousness of the findings and any mitigating or aggravating factors
c. ensuring the doctor has adequate time to remediate…

101. The tribunal's primary consideration should be public protection and the seriousness of the findings. Following any remediation, the time all parties may need to prepare for a review hearing if one is needed will also be a factor.'

225. The Tribunal determined that a 12-month suspension would provide sufficient time for Dr Monro to reflect on her misconduct and develop insight. A long suspension order is the most appropriate and proportionate sanction in this case.

Erasure

226. In considering erasure, the Tribunal took account of paragraph 108:

108 Erasure may be appropriate even where the doctor does not present a risk to patient safety, but where this action is necessary to maintain public confidence in the profession. For example, if a doctor has shown a blatant disregard for the safeguards designed to protect members of the public and maintain high standards within the profession that is incompatible with continued registration as a doctor.

109 Any of the following factors being present may indicate erasure is appropriate (this list is not exhaustive).

a. A particularly serious departure from the principles set out in Good medical practice where the behaviour is fundamentally incompatible with being a doctor.
b. A deliberate or reckless disregard for the principles set out in Good medical practice and/or patient safety
...
j. Persistent lack of insight into the seriousness of their actions or the consequences.

227. Although Dr Monro did not comply with principles in GMP at the relevant time, the Tribunal did not consider this (past) behaviour to be fundamentally incompatible with continued registration.

228. The Tribunal considered that, in all the circumstances, erasure was not required to protect the public interest.

Review

229. The Tribunal directed a review of Dr Monro's case. A review hearing will convene shortly before the end of the period of suspension. At the review hearing, the onus will be on

Dr Monro to demonstrate any insight or remediation. It would assist the reviewing Tribunal to be provided with a reflective statement from Dr Monro.

230. Dr Monro will also be able to provide any other information that she considers will assist.

Determination on Immediate Order - 28/04/2023

231. Having determined that Dr Monro's registration be subject to suspension for a period of 12 months, the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether her registration should be subject to an immediate order.

Submissions

232. On behalf of the GMC, Mr Hamlet submitted that Dr Monro's interim order should be revoked, as the suspension order imposed by this Tribunal supersedes the interim order.

233. Mr Hamlet referred the Tribunal to paragraph 172 of the Sanctions Guidance (the SG). He submitted that an immediate order is necessary to protect the public interest which includes the need to maintain public confidence in the medical profession.

The Tribunal's Determination

234. The Tribunal has taken account of the paragraphs 172 and 173 of the SG:

> *'172. The tribunal may impose an immediate order if it determines that it is necessary to protect members of the public, or is otherwise in the public interest, or is in the best interests of the doctor…*
>
> *173. An immediate order might be particularly appropriate in cases where the doctor poses a risk to patient safety. For example, where they have provided poor clinical care or abused a doctor's special position of trust, or where immediate action must be taken to protect public confidence in the medical profession.'*

235. The Tribunal decided that an immediate order is required to maintain public confidence in doctors, in all the circumstances.

236. The direction to suspend Dr Monro's name from the medical register will take effect 28 days from when notice is deemed to have been served upon her unless she lodges an appeal in the interim. A note explaining her right of appeal will be sent to Dr Monro. If Dr Monro lodges an appeal, the immediate order of suspension will remain in place until such time as the outcome of any appeal is determined.

237. The interim order currently imposed on Dr Monro's registration is hereby revoked.

238. That concludes this case.

ANNEX A – 11/04/2023

Application on Service and proceeding in absence

239. Dr Monro is neither present nor represented today at this Medical Practitioners Tribunal ('MPT') hearing. The Tribunal therefore considered whether the relevant documents had been served in accordance with General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'), and paragraph 8 of the fourth Schedule to the Medical Act 1983.

Submissions

240. Mr Hamlet submitted that the requirements of Rules 15, 31 and 40 had been satisfied. Relevant documents had been emailed as well as posted to Dr Monro's registered address, so all reasonable efforts had been made to serve the Notice of Hearing and other information.

241. Mr Hamlet referred the Tribunal to the relevant documents in the service bundle. Mr Hamlet also referred the Tribunal to the GMC's email to Dr Monro's legal representative, dated 27 February 2023, in relation to a Voluntary Erasure application. He said that no decision had been made by the Voluntary Erasure Application Liaison Team (VERL). He said that although this email is not relevant to service it may be relevant to the Tribunal's decision to proceed in the doctor's absence.

242. Mr Hamlet referred the Tribunal to the email dated 31 March 2023 from Mr Simon Gomersall of Weightmans and said that it makes clear that Dr Monro does not wish to participate in the hearing, indicating that Dr Monro is aware of today's hearing.

243. Mr Hamlet submitted that the Allegation is relatively serious and that it is in the public interest to proceed today, taking account of principles in *R v Jones (2001) EWCA Crim 168.* Mr Hamlet said that Dr Monro had acknowledged receipt of the Notice of Hearing, was aware of these proceedings and had decided not to attend. He submitted that there is no risk of disadvantage to Dr Monro if the Tribunal proceeds in absence.

Service

244. The Tribunal took account of the screen shot of Dr Monro's registered address and considered that the Notice of Allegation letter had been emailed to Dr Monro's legal representative, Mr Alex Leslie of Weightmans, on 24 February 2023.

245. The Tribunal had evidence that the MPTS Notice of Hearing had been emailed to Dr Monro on 8 March 2023 and sent by recorded delivery to her registered address on 10 March 2023. The Tribunal took account of the Royal Mail proof of delivery document indicating that the Notice of Hearing had been delivered on 11 March 2023.

246. The Tribunal considered an email dated 31 March 2023 from Dr Monro's legal representative, Mr Simon Gomersall of Weightmans, saying:

> *'I acknowledge this correspondence below and other recent emails from both the GMC and the MPTS…'*

247. The Tribunal took account of all documents provided and submissions made by Mr Hamlet. Dr Monro's legal representatives had been in communication with the GMC as to the Allegation and dates of hearing. Therefore, the Tribunal was satisfied that notice of this hearing had been served in accordance with Rules 20 and 40.

Proceeding in absence

248. As the Tribunal was satisfied that notice had been properly served on Dr Monro, the Tribunal then considered whether to proceed in her absence under Rule 31.

249. The Tribunal took account of the email dated 31 March 2023 from Mr Simon Gomersall, Weightmans which said:

> *'…I write on instructions to confirm that Dr Monro does not wish to participate in the MPTS proceedings and will neither be present nor represented at the hearing beginning on 11 April 2023. She is content for it to proceed in her absence, which will be voluntary. No disrespect is meant to the GMC or to the Tribunal by this decision.'*

250. The Tribunal took account of principles in *R v Jones (2001) EWCA Crim 168*. The discretion to proceed in the absence of a doctor must be exercised with great caution, balancing the interests of the doctor with the wider public interest, including the need to proceed expeditiously.

251. Correspondence from Weightmans indicated that Dr Monro does not wish to participate in these Tribunal proceedings and is absent voluntarily. Dr Monro has not applied for this hearing to be adjourned, so there is no indication that Dr Monro would attend a hearing in the future.

252. In all the circumstances, taking account of the relevant law and Rules, the Tribunal considered that there is a clear public interest in proceeding with the hearing and that it would not be unfair to Dr Monro to proceed in absence. The Tribunal determined to proceed with this hearing in Dr Monro's absence.

ANNEX B – 13/04/2023

Application for Voluntary Erasure

253. Dr Munro made an application to the General Medical Council (GMC) for voluntary erasure (VE application) on 24 February 2023 under the GMC (Voluntary Erasure and Restoration following Voluntary Erasure) Regulations Order of Council 2004/2609 (VE Regulations).

254. The GMC referred the VE application to this Tribunal for it to decide whether to allow her to be voluntarily erased. Dr Munro's legal representatives Weightmans LLP provided written submissions dated 20 February 2023. Dr Munro was not present or represented at the Tribunal hearing.

Evidence

255. The Tribunal considered written evidence and skeleton arguments from the GMC as well as Dr Monro. Documents in the hearing bundles included the following:

- Dr Monro's VE application submitted on 24 February 2023
- Skeleton Argument on behalf of Dr Monro dated 20 February 2023
- GMC Rule 8 letter and Annex dated 13 January 2023
- Skeleton Argument in response from the GMC
- An email to the GMC dated 14 July 2022 relating to a new fitness to practise investigation – substance of allegation redacted
- GMC guidance '*Guidance on making decisions on voluntary erasure applications and advising on administrative erasure'* dated March 2021 (the VE guidance)
- GMC guidance *'Making decisions on cases at the end of the investigation stage: Guidance for the Investigation Committee and case examiners'* dated March 2021 (Guidance 1).

Submissions

256. Written submissions on behalf of Dr Munro from Weightmans dated 20 February 2023 made seven main points, reproduced below:

> '*First, Dr Monro is now aged 86 and she relinquished her licence to practise medicine in August 2021 and there is no prospect that she will seek to re-register in the event that her application for Voluntary Erasure is now granted. The Annual Retention Fee has not been paid in furtherance of her wish to cease practising medicine and the relinquishment of her registration. There is no evidence that she has done so to avoid the fitness to practise investigation which has been ongoing. While the imposition of conditions that could never reasonably have been satisfied were a factor in Dr Monro's decision to cease practising medicine that is a factor in support of her application. It*

demonstrates realism and insight in recognising that, after being out of practise for the lengthy period between that interim order (which was later converted to suspension) being made and the likely date of any substantive hearing, she would at her age be unlikely to be able to return to practise medicine.

Second, the current investigation was prompted by a complaint dated 21 June 2017 in respect of her part in the care of Patient A, as now identified. The GMC has had ample opportunity to discover, investigate, and pursue allegations about the whole of Dr Monro's practise in the more than 5 years since that complaint and the 2 cases in the Rule 15 Notice represent the full extent of the case against her. There is no prospect that further matters will be discovered and pursued before the hearing in April 2023.

Third, at paragraph 48 of the GMC's Guidance it is envisaged that a decision may be deferred if further significant information might be collected. Now, there is no prospect of further significant information. Because of the age of the allegations memories have already faded and/or is not available. You have sought such expert evidence as you think appropriate and had ample opportunity to seek alternative or further expert evidence if you wished. The point has now been reached where a re-evaluation of the application is appropriate.

Fourth, in referring the allegations now in the Rule 15 Notice the Case Examiners only had to conclude that there was a realistic prospect of the allegations being proved. Since that test envisages referral if there is a better than 50:50 chance of proving the allegations it follows that there may be a significant chance, up to 49:51, of the allegations not being proved. In our submission that does not recognise the reality the allegations are not admitted and will have to be proved. On the present evidence, there is a better than 50:50 prospect that the allegations will not be proved, particularly when account is taken of the matters set out above in relation to the specific cases. The care of 2 patients is not the basis for a conclusion that there has been persistent breach of professional standards. While any allegations are serious those in this case are not of the most serious or significant kind in the spectrum of allegations considered by the GMC and determined by the Tribunal.

Fifth, the allegations relate solely to Dr Monro's performance as a medical practitioner, which included at the time being the Medical Director of the Breakspear Clinic. Paragraph 43 of the Guidance anticipates grant of the application in such circumstances where, as here, any future patients will be protected by the grant as Dr Monro will not be able to practise medicine, even if she wished (and she does not).

Sixth, none of the matters in the Rule 15 Notice carry a presumption of impairment, as set out in paragraph 23 of the Council's Guidance on Voluntary Erasure. The allegation that Dr Monro practised medicine in breach of the interim conditions and without a licence to practise is no longer relevant. By the letter dated 13 January 2023, the GMC notified Dr Monro that its Case Examiners had concluded that there was no realistic prospect of proving those allegations and that investigation was closed with no action

on her registration. Accordingly, sub-paragraph (f) is not relevant to this consideration. Further, in neither of the 2 cases does the GMC expert say that the care provided was grossly negligent or reckless in any respect. Further, the Rule 15 Notice does not include such an allegation and such an allegation could not now fairly be made. The disclosed evidence does not support such an allegation and the Tribunal would not be entitled to make such a finding or reach such a conclusion.

Seventh, there is no public interest in a hearing of the allegations, whether or not Dr Monro participated. And, as you will have seen, she intends not to take part in the substantive hearing. There is a public interest in the efficient resolution of concerns about fitness to practise. Granting her application for erasure is the most efficient way of resolving the real issue, which is whether her fitness to practise is impaired to a degree warranting action on her registration.

In conclusion, we commend Dr Monro's application to the Tribunal and invite the Tribunal to grant her application.'

GMC Submissions

257. The GMC opposed the VE application. Mr Hamlet made submissions to the Tribunal on behalf of the GMC, emphasising the relevance of all written evidence in support of the Allegation.

258. Dr Monro was a doctor specialising in environmental medicine at all relevant times. Dr Monro was Medical Director for Breakspear Medical, a private clinic specialising in diagnosis and treatment of allergies, sensitivities, and other conditions. The Allegation concerns Patient A, an adult and Patient B, a child.

Patient A

259. Mr Hamlet said that, since 2009, Dr Monro was the doctor with primary responsibility for the care of Patient A, a 37-year-old woman. Patient A complained of various symptoms including chronic fatigue, after exposure to dry cleaning chemicals at work. Mr Hamlet submitted that Patient A had developed a panic or anxiety response.

260. Dr Monro diagnosed Patient A as having multiple chemical sensitivities (MCS). Dr Monro is alleged to have reinforced Patient A's erroneous beliefs about her health condition. It is alleged that this led to the imposition of severe restrictions on her diet and other aspects of life, causing an adverse impact of her mental and physical health, as well as her finances, due to the high cost of treatment advised by Dr Monro.

261. It is further alleged that Dr Monro's treatment of Patient A, with low dose immunotherapy and Brussels sprout extract, was inappropriate and ineffective. Dr Monro allegedly failed to assess or speak directly with Patient A, from June

2009 to January 2021, despite the apparent deterioration in her health. Mr Hamlet also submitted that Dr Monro failed to respond appropriately to an episode of self-harm by Patient A, when she became aware of it in September 2020. The GMC alleges that Patient A became severely unwell as a direct result of advice and treatment from Dr Monro. in February 2021 Patient A was admitted to an NHS hospital with severe malnutrition and vitamin deficiencies described by clinicians as 'life threatening' as a consequence of acts and/or omissions by Dr Monro.

262. Mr Hamlet suggested that Dr Monro could plausibly be described as having demonstrated a reckless disregard of the risk of serious harm towards Patient A.

Patient B

263. Mr Hamlet said that Patient B, aged five at relevant times, was referred to Breakspear by his parents 'for an environmental perspective on his problems'. He was described as having 'lymphoid hyperplasia and infiltration' as well as 'small intestinal bacterial overgrowth and dysbiosis'. The GMC allege that Dr Monro failed initially to establish what prior investigations had been undertaken by other clinicians, or to find out what care, diagnosis and treatment had already been offered. In addition, Dr Monro had not considered the possibility of Fabricated and Factitious Illness ('FFI') as required in this case, or any necessary safeguarding measures.

264. Instead, Dr Monro referred Patient B to a Dr J, a Consultant Neurophysiologist for assessment with a Neuroscope, a diagnostic machine described as 'experimental' by a GMC expert. Dr Monro is alleged to have endorsed Dr J's inappropriate use of the Neuroscope and oxygen-mask treatment, despite Dr Monro having primary clinical responsibility for Patient B.

265. Advice that Patient B should wear an oxygen facemask for several hours a day (an experimental 'treatment' with no proven benefit) had potential to cause psychological harm and was not in his best interests. Dr Monro had a duty to provide sufficient information to Patient B's parents to enable them to give informed consent, but it is alleged that Dr Monro did not do so.

266. Mr Hamlet acknowledged that the GMC could not adduce evidence of actual harm to Patient B. However, actions or omissions with the potential to cause harm to a child patient amount to serious breaches of the standards expected of a doctor.

267. Mr Hamlet submitted that GMC Guidance to Case Examiners should be considered by this Tribunal. The Tribunal should take account the VE Guidance as well as Guidance 1.

268. A Summary of Key Principles in the VE guidance says at paragraph 9:

> *'9. Case examiners should consider the following key principles when making VE decisions and giving advice on AE.*

a. The different factors in an individual case should be balanced against each other to make an overall assessment of whether erasure is in the public interest. The GMC's overarching objective is to protect, promote and maintain the health and safety of the public. This is broken down into three limbs:

i to protect, promote and maintain the health, safety and well-being of the public
ii to promote and maintain public confidence in the medical profession
iii to promote and maintain proper professional standards and conduct for doctors'

269. Mr Hamlet referred to paragraph 11 of the VE Guidance directing that Case Examiners, or, he submitted, the Tribunal:

'…should be satisfied that it is right in all the circumstances to grant VE…'

270. Mr Hamlet said that the VE Guidance says that the seriousness of the concerns should be weighed against the *'likelihood of the doctor returning to practice'* and the GMC's *'ability to revive the allegations should the doctor apply for restoration'.*

271. Mr Hamlet submitted that, even if a doctor has no intention to resume medical practice, the Tribunal should consider whether allowing VE would undermine public confidence in the medical profession.

272. Mr Hamlet submitted that *'on the face of it, the public will be protected by a decision to allow erasure as the doctor will no longer be able to practise medicine and any risk to patients is removed:' paragraph 13.*

273. However, Mr Hamlet reminded the Tribunal of paragraph 16 directing that Case Examiners, or the Tribunal:

'…should assess the seriousness of the allegations and whether it would undermine public confidence in the medical profession if they were not fully investigated. This may involve the allegations being heard in public at a tribunal hearing and the doctor receiving a sanction. This, in itself, strengthens public confidence that proper standards of conduct and performance are being upheld.'

274. Mr Hamlet said that points made by Dr Monro must be weighed against the public interest in the Allegation proceeding to a Tribunal. A full hearing, he submitted, has potential to strengthen public confidence in the medical profession. The focus of the Tribunal should not be on the individual circumstances of the doctor but on the wider public interest, including the need to maintain confidence in the profession.

275. Mr Hamlet said that the extent to which public confidence is relevant will vary according to the circumstances of each case. The Tribunal should consider paragraph 17:

'…there is a clear public interest in cases involving serious convictions or serious misconduct being fully considered in accordance with our fitness to practise procedures.'

276. In relation to the maintenance of proper standards and conduct, Mr Hamlet referred to paragraph 21:

'Where it is alleged that a doctor has significantly and/or persistently breached the professional standards we set for doctors, this gives rise to a public interest in the alleged breached being properly investigated (with a public hearing held in some cases) and not evaded.'

277. Mr Hamlet submitted cases at the more serious end of the spectrum should proceed to a fitness to practise hearing. GMC Guidance at paragraph 47 says that VE:

'…should usually be refused in cases of a serious nature involving allegations of misconduct, ongoing police investigations or convictions…[where]…public confidence in doctors would be undermined if a full investigation did not take place.'

278. Mr Hamlet submitted that the relative seriousness of the Allegation against Dr Monro requires a full Tribunal hearing to maintain public confidence in doctors.

279. Although Dr Monro has relinquished her licence to practise (and is unlikely to return to medical practice) Mr Hamlet submitted that this fact does not displace the significant public interest in determining the serious Allegation of impaired fitness to practise due to alleged misconduct.

280. Mr Hamlet said that there is an ongoing investigation against Dr Monro in relation to an outstanding allegation. It cannot be said that the Allegation above amounts to the sole concern in relation to Dr Monro.

281. In relation to points made by Weightmans on behalf of Dr Monro, Mr Hamlet said that the only factual evidence subject to challenge is that from the mother of Patient B. Otherwise the 'factual' non-expert witness evidence appears to be uncontested.

282. Mr Hamlet reminded the Tribunal that this is not a performance case. The only ground of alleged impairment is misconduct.

283. Mr Hamlet referred the Tribunal to paragraph 24 of Guidance 1 from the GMC:

'24 There are certain categories of case where the allegations, if proven, would amount to such a serious failure to meet the standards required of doctors, that there will be a presumption of an issue of impaired fitness to practise. These tend to fall within seven main headings:

…..

h) gross negligence or recklessness about a risk of serious harm to patients.'

284. Mr Hamlet submitted that there is a public interest in this Allegation being heard. If Dr Monro were to apply for restoration in the future, Mr Hamlet submitted that these allegations would be difficult to re-open, due to lapse of time, witness availability and the fading of memory. In all the circumstances Mr Hamlet asked the Tribunal to refuse the VE Application from Dr Monro.

Advice from the Legally Qualified Chair

285. The Tribunal must balance factors relevant to this particular case, taking account of the overarching objective to protect, promote and maintain public health and well-being of the public, maintain public confidence in the medical profession and uphold professional standards and conduct. The Tribunal must take account of a doctor's ability to apply for restoration at any time after VE and any potential risk to the public if restored. Restoration is not automatic. A doctor cannot be restored with conditions or undertakings.

286. The Tribunal should assess the likelihood of any restoration application and the ability of the GMC to revive unresolved allegations, taking account of the impact of lapse of time on memory. The Tribunal should ask if it would undermine public confidence to allow VE given that Allegation would not then be fully considered by a Tribunal. The Tribunal should consider whether there has been a significant and/or persistent breach of professional standards. If so, it should take account of the public interest in evidence being assessed by a full Tribunal hearing. The Tribunal should consider paragraph 23 of the VE Guidance. This provides that there is a rebuttable presumption that VE would not be in the public interest (unless exceptional circumstances apply) if there is an allegation of gross negligence or recklessness about risk of serious harm to patients: at paragraph 23(h). Exceptional circumstances include factors such as very serious illness, as well as cases where the Allegation is at lower end of spectrum of seriousness.

287. The Tribunal must consider the application for VE in the context of submissions by Dr Monro, as well as the GMC, taking account of relevant documents and guidance. There was no comment on the legal advice from counsel and the Tribunal accepted it.

The Tribunal's Approach

288. Dr Monro made an application for Voluntary Erasure under the VE Regulations which provide that:

"Where, on the date the Registrar receives an erasure application, an allegation against the practitioner has been referred to a FTP Panel under the Fitness to Practise Rules and the hearing before the FTP Panel has commenced, the Registrar shall refer

the application for determination by the FTP Panel, and the application shall be determined by the FTP Panel accordingly."

289. The Fitness to Practise Rules 2004 do not provide any specific procedure for the determination of a VE application. However, the Tribunal took account of all relevant provisions in the VE Guidance and Guidance 1.

290. The Tribunal took account of paragraph 11 of the VE Guidance which says:

'Case examiners should be satisfied that it is right in all the circumstances to grant VE [...].

The Tribunal's Decision

291. The Tribunal took account of the statutory overarching objective to protect the public and the wider public interest. It considered submissions on behalf of Dr Monro, including the fact that she is now aged 86 and relinquished her licence to practise in August 2021. Weightmans submitted that Dr Monro has no intention to apply for restoration, if granted VE, and also that there is no evidence that Dr Monro has sought VE to avoid any ongoing fitness to practise investigation.

292. The Tribunal considered the seriousness of the Allegation, the lapse of time since the events in question, the fact that Dr Monro has relinquished her licence to practise and the likelihood of any future application for restoration if erased.

293. The Tribunal took account of the substance of the Allegation, that Dr Monro failed to provide good clinical care to two patients. The GMC allege that Dr Monro's actions or omissions in relation to assessment, diagnosis, advice and treatment raise concerns about informed consent and safeguarding. It is alleged that Dr Monro's conduct caused actual, or potential, harm to patients.

294. The Tribunal considered the likelihood of Dr Monro, aged 86, returning to clinical practice. Dr Monro relinquished her licence to practise on 25 August 2021.

295. The GMC Case Examiner's report dated 12 January 2023 says:

'It appears that Dr Monro initially practised as a general practitioner (GP) in her private practice which became Breakspear Medical Group. She is currently one of three directors at Breakspear Medical... The Breakspear website identifies that:

• Dr Monro works there as an environmental naturopath having retired from the practice of medicine in 2021, surrendering her GMC licence on 25 August 2021, and commencing practise as a naturopath.
• Dr Monro is registered with two UK organisations; the General Naturopathic Council (GNC) and the Association of Naturopathic Practitioners (ANP).

296. The Tribunal considered the likelihood of Dr Monro returning to medical practice to be low, taking account of her age and stated intention. However, Dr Monro appears to have been working as a naturopath in January 2023 and would be entitled to apply for restoration to the medical register at any time following voluntary erasure.

297. The Tribunal considered paragraph 23 of the VE Guidance to be relevant. It says:

> *'The following are examples of cases where (except in exceptional circumstances) it will not be in the public interest to allow voluntary erasure or proceed with administrative erasure before the conclusion of fitness to practise proceedings, including a MPT hearing in some cases. This is because they involve a conviction for a serious criminal offence or the allegation carries a presumption of impaired fitness to practise. ….*
>
> *h) Allegations of gross negligence or recklessness about a risk of serious harm to patients.*
>
> *The above is not an exhaustive list and there is clearly a public interest in allowing all allegations of serious misconduct to be fully investigated and, if there is a realistic prospect of establishing impairment, ventilated in public at a tribunal.'*

298. The GMC case is that the Allegation before the Tribunal amounts to an allegation that Dr Monro was reckless as to the risk of serious harm to at least one patient. It is submitted that Patient A required hospital treatment for malnutrition as a direct result of following advice from Dr Monro. Mr Hamlet also submitted that Patient B was at risk of psychological harm from wearing an oxygen mask for several hours a day when there was no sound clinical reason for doing so. The Tribunal considered that the Allegation in relation to Patients A and B raises concerns about risk to patients.

299. The Tribunal was aware that the list of factors indicating a presumption of impairment is not exhaustive. It assessed the Allegation as a whole to be relatively serious, because, if proved, there is a realistic prospect of a reasonable Tribunal, properly directed as to the law, finding current fitness to practise to be proved by reason of misconduct.

300. The Tribunal considered whether there were any exceptional circumstances in this case, taking account of paragraph 24 of Guidance 1:

> *'There may sometimes be exceptional circumstances when it is appropriate to allow voluntary or administrative erasure prior to the conclusion of the fitness to practise process, even if a case falls into one of the categories above.'*

301. As there was no indication that Dr Monro is very unwell or lacks capacity to take part in legal proceedings, the Tribunal considered whether it could plausibly be argued that the Allegation falls at the lower end of a spectrum of seriousness. In view of the alleged risks

caused to patients and consequent impact on public confidence in the medical profession, the Tribunal considered the Allegation to be relatively serious.

302. The Tribunal considered there were no exceptional circumstances to justify allowing VE.

303. If VE were to be granted the lack of a public hearing into the Allegation would have potential to undermine public confidence in the medical profession and regulator.

304. The Tribunal considered that the Allegation against Dr Monro is sufficiently serious to require consideration by a fitness to practise Tribunal. This is necessary to protect the public, maintain confidence in doctors and uphold proper standards; all three limbs of the overarching objectives are potentially engaged. The Tribunal considered that it would not be right in all the circumstances to grant Dr Monro's application for to Voluntary Erasure.

305. Accordingly, the Tribunal refused Dr Monro's application for Voluntary Erasure.

ANNEX C – 18/04/2023

Application under Rule 34(1)

306. Mr Hamlet made an application to adduce the witness statement of Ms C, mother of Patient B, dated 27 March 2019. Mr Hamlet said that legal representatives for Dr Monro indicated that admission of this statement is 'not agreed'. At a pre-hearing meeting in November 2022, the following minutes were recorded by the MPTS:

> *'GMC representative 'JM further advised that [Ms C] has also confirmed she will no longer be engaging and the GMC will therefore be making an application to admit her statement if the evidence is not agreed. AL confirmed [on behalf of Dr Monro] that this will not be agreed.'*

307. Mr Hamlet said that references to 'Patient A' in this statement should be understood as references to Patient B, who is the subject of paragraph 3 of the Allegation. Mr Hamlet submitted that the statement of Ms C is relevant to, although not determinative of paragraph 3. However, Mr Hamlet said that other statements largely cover the same points.

308. Mr Hamlet said that no 'defence' representative is attending this hearing to ask any questions on behalf of Dr Monro, so there is no specific challenge by the doctor's legal representatives to any part of Ms C's statement. In answer to a question from the Legally

Qualified Chair, Mr Hamlet said that the GMC intends to proceed with paragraph 3 of the Allegation, whether this statement is admitted or not.

309. The LQC advised the Tribunal to take account of Rule 34. Firstly, the Tribunal must consider whether the evidence is relevant to any key issue in dispute. Secondly, if deemed relevant, the Tribunal must consider whether it would be fair to admit the evidence in all the circumstances.

The Tribunal Decision

310. The Tribunal considered Rule 34(1) of the Rules:

> *'The Tribunal may admit any evidence they consider fair and relevant to the case before them, whether or not such evidence would be admissible in a court of law.'*

311. The Tribunal did not consider that Ms C's statement provided cogent evidence in relation to any disputed issue which it had to determine. Although it may be seen as providing background context, the Tribunal was unable to identify any clear evidence relevant to a key issue in dispute.

ANNEX D – 25/04/2023

Invitation to amend the Allegation under Rule 17(6)

312. After oral evidence had concluded, Mr Hamlet made closing submissions. His written skeleton argument included an invitation to amend the Allegation under Rule 17(6):

> *'It is open to the tribunal… to amend charge 1ai to reflect the express references to "electrical sensitivity"… if it is considered a) necessary and b) achievable without generating injustice.'*

313. The original version 1(a)(i) said:

> *'1. Between 5 May 2009 and 25 January 2021 your care and treatment of Patient A was inadequate in that you:*
>
> *a. inaccurately diagnosed her with:*
>
> *i. sensitivity to electromagnetic radiation, including sunlight;*

314. Mr Hamlet invited the Tribunal to consider replacing '*sensitivity to electromagnetic radiation, including sunlight'* with '*electrical sensitivity',* as this amendment would correct an inaccuracy in Dr H's report. He submitted that this amendment would cause no injustice to Dr Munro, as it would relate to only one diagnosis and would not widen the scope of the Allegation.

The Tribunal's Decision

315. The Tribunal considered Rule 17(6) of the Rules:

> *'(6) Where, at any time, it appears to the Medical Practitioners Tribunal that—*
>
> > *(a) the allegation or the facts upon which it is based and of which the practitioner has been notified under rule 15, should be amended; and*
> >
> > *(b) the amendment can be made without injustice,*
>
> *it may, after hearing the parties, amend the allegation in appropriate terms.'*

316. The Legally Qualified Chair advised the Tribunal to consider Rule 17(6) as well as the timing of the invitation by Mr Hamlet on behalf of the GMC.

Decision

317. On Day Five, [17/04/23] the Legally Qualified Chair (LQC) had asked the GMC to make any application to amend the Allegation before oral evidence was heard. This was to minimise the risk of any injustice to Dr Monro.

318. On Day Nine [21/04/2023] of the hearing, after all evidence had been heard, Mr Hamlet invited the Tribunal to consider amending the Allegation. Dr Monro was not present and was not represented, so could not respond.

319. The Tribunal considered that amending the Allegation to reflect the evidence of a GMC witness may increase the likelihood of the GMC being able to prove it to the civil standard, to the potential detriment of Dr Monro. As the GMC had received expert reports several weeks earlier, the Allegation could have been drafted to reflect words used in Dr H's conclusion. Counsel received expert reports before any oral evidence was heard and could have made a Rule 17 application to amend after the Case Examiners refused Dr Monro's VE application.

320. In all the circumstances, the Tribunal considered that the Allegation could not be amended, at this stage, without injustice to Dr Monro. Therefore, the Tribunal did not consider it fair or appropriate to amend the Allegation.