PUBLIC RECORD

Dates: 22/05/2024 - 05/06/2024
13/08/2024 - 16/08/2024

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
Review - Misconduct	Facts relevant to impairment found proved	Impaired

Summary of outcome

Erasure
Immediate order imposed

Tribunal:

Legally Qualified Chair:	Miss Debi Gould
Lay Tribunal Member:	Mrs Debbie Hill (22/05/2024 - 03/06/2024
Medical Tribunal Member:	Mr Gulzar Mufti (22/05/2024 - 05/06/2024, ((13/08/2024 - 16/08/2024) Dr Nagarajah Theva (04/06/2024 - 05/06/2024) Dr Deborah Brooke (13/08/2024 - 16/08/2024)

Tribunal Clerk:	Miss Emma Saunders (22/05/2024 - 03/06/2024) Mr Andrew Ormsby (04/06/2024 - 05/06/2024) Miss Ciara Fogarty (13/08/2024 - 16/08/2024)

Attendance and Representation:

Medical Practitioner:	Not present, not represented
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 partly in public and partly in private.

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 - 03/06/2024

Background

1. Dr Monro qualified in 1960. At the time of the events, Dr Monro was the Medical Director at Breakspear Medical Ltd ('Breakspear'), which is a private clinic. In July 2023, Dr Monro stated that she was an Environmental Naturopath and had retired as a medical practitioner several years ago.

2. The Allegation that has led to Dr Monro's hearing relate to her actions in respect of the care provided to Patient A (then aged 5 years). Patient A's parents state that Patient A inhaled mouldy water in her grandmother's bathroom after sucking on a rubber duck in early 2019. They say that Patient A became unwell not long afterwards and were concerned that this was caused by the mould. Patient A underwent tests via the NHS including a bronchoscopy and nothing to support this was found. Patient A's parents then decided to contact Breakspear to seek private medical care as Patient A was still unwell.

3. Patient A's parents made initial enquiries with the Breakspear reception team and then completed a Breakspear Child Medical Questionnaire dated 30 April 2020 in respect of Patient A. Following that, they had a telephone consultation with Dr Monro on 29 July 2020. Patient A was subsequently seen by Dr C, a Physician at Breakspear, in the outpatient clinic on 10 September 2020 for a physical examination.

4. Following that physical examination, Dr Monro advised that a series of tests should be performed including a Mycotoxin test. Patient A's parents, for financial reasons, decided that they could only afford the Mycotoxin test. Patient A's parents provided a sample of Patient A's urine via a kit provide by Breakspear in order that this test could be carried out.

5. Upon receipt of the test results, on 1 October 2020 Dr Monro spoke with Patient A's mother on the telephone. She advised that the test results showed that Ochratoxin A ('OTA') was present at abnormally elevated levels. Dr Monro made a number of recommendations for Patient A. Patient A's parents were also given a cost estimate in relation to various items.

6. Patient A's parents went back to the NHS with Dr Monro's diagnosis, however, this and the treatment plan was questioned by the paediatrician responsible for her care. Patient A was discharged from services at Breakspear via a letter from Dr Monro on 18 November 2020.

7. It is alleged by the General Medical Council (GMC) that, between 30 April and 18 November 2020, Dr Monro failed to provide good clinical care to Patient A, in the manner set out in the Allegation below. It is alleged that Dr Monro's failings related to history taking, examination, diagnosis, investigation, record keeping, prescribing and consent. It is also alleged by the GMC that, on 29 July 2020, Dr Monro inappropriately prescribed Nutrisorb Liquid Zinc Plus Ascorbate 30 millilitre and Bio D 15ml for protection against Covid, when she had no evidence of its efficacy against Covid. Further, it is alleged that, on 20 October 2020, Dr Monro prescribed Chlorella to Patient A claiming it had medicinal properties in removing mould toxins, which was inappropriate.

8. Initial concerns were raised with the GMC via the completion of a GMC complaint form dated 17 April 2023 by Patient A's father. A response to the Allegation was received via correspondence on Dr Monro's behalf primarily from Mr D, XXX who is the Registered Manager/Managing Director of Breakspear.

The Outcome of Applications made during the Facts Stage

9. The Tribunal determined that service of the notice of this hearing had been effected in accordance with Rule 40 of the GMC (Fitness to Practise) Rules 2004 as amended ('the Rules'), and paragraph 8 of Schedule 4 to the Medical Act 1983, as amended. The Tribunal also determined to proceed with the hearing in Dr Monro's absence in accordance with Rule 31 of the Rules. The Tribunal's full decision on this matter is included at Annex A.

10. The Tribunal granted the GMC's application, made pursuant to Rule 17(6) of the Rules, for amendment to paragraphs 1(a), 1(f)(i) and 1(f)(iii)(2) and (3) of the Allegation. The Tribunal's full decision on the application is included at Annex B.

The Allegation and the Doctor's Response

11. The Allegation made against Dr Monro is as follows:

That being registered under the Medical Act 1983 (as amended):

1. Between 30 April 2020 and 18 November 2020 you were involved in the care and treatment of Patient A. You failed to provide good clinical care in that you:

a. did not take an environmental history to establish whether there were any ongoing risks of exposure to fungal or other toxins in Patient A's environment, including from:
Amended under Rule 17(6)

i. ongoing exposure to moulds;
To be determined

ii. consumption of foods potentially high in Ochratoxin A ('OTA');
To be determined

b. did not ensure an examination of Patient A's:

i. pulse rate and blood pressure;
To be determined

ii. abdomen;
To be determined

was carried out;

c. did not make an appropriate differential diagnosis based on the presenting symptoms;
To be determined

d. arranged investigation by Mycotoxin urine test ('the Test') which was inappropriate to explore the possibility of illness due to fungal infection;
To be determined

e. did not record the relevance of the Test results to Patient A's condition and treatment;

To be determined

f. provided information to Patient A's parents based on the Test's laboratory report ('the Report'):

i. which asserted that the Test was done in a ~~CILA~~ CLIA approved laboratory before verifying that it was accredited;
Amended under Rule 17(6)
To be determined

ii. by providing an incomplete transcript of the Report without clinical context;
To be determined

iii. without alerting them to:

1. the limitations of the Test;
To be determined

2. the fact that it was performed in a laboratory that did not conform to NHS standards;
Amended under Rule 17(6)
To be determined

3. the fact that it was not approved in the United States;
Amended under Rule 17(6)
To be determined

4. which (if any) of the toxic effects outlined in the Report had been experienced by Patient A;
To be determined

5. whether any further investigations were necessary to explore the possibility of such toxic effects;
To be determined

6. how further exposure could be prevented;
To be determined

iv. which, in the alternative to paragraph 1.f.iii, having alerted them to the features set out in paragraph 1.f.iii and believing that Patient A did not have toxicity, you failed to:

1. reassure Patient A's parents;
To be determined

2. explain the reason for needing treatment;
To be determined

g. inappropriately recommended cholestyramine for Patient A which is not licensed for:

i. children;
To be determined

ii. the reduction in OTA levels;
To be determined

2. On 29 July 2020 you inappropriately prescribed to Patient A:

a. Nutrisorb Liquid Zinc Plus Ascorbate 30 millilitre ('ml') ten drops daily;
To be determined

b. Bio D 15ml, four drops once daily;
To be determined

for protection against COVID, when you had no evidence of its efficacy against Covid.

3. On 20 October 2020 you prescribed Chlorella to Patient A claiming it had medicinal properties in removing mould toxins, which was inappropriate as:

a. there was no scientific basis for this claim;
To be determined

b. it had the potential to cause harm in terms of the side effects and allergic reactions;
To be determined

c. those with allergy to moulds can be allergic to Chlorella;
To be determined

d. you failed to discuss the matters described in paragraphs 3.b. and 3.c. with Patient A's parents before prescribing;
To be determined

e. you knew obtaining this prescription would result in a heavy financial burden to Patient A's parents.
To be determined

4. On or after 30 April 2020 you failed to obtain adequate consent in your assessment and treatment of Patient A in that you did not explain the implications of agreeing to the administration of unregulated investigations and unlicensed medication.

To be determined

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

To be determined

Witness Evidence

12. The Tribunal received evidence on behalf of the GMC from Patient A's mother on 24 May 2024. Her witness statement is dated 29 February 2024.

13. Dr Monro did not provide her own witness statement but did provide written response to the Rule 15 Allegation in a letter dated 12 April 2024. There were also a few other emails sent to the GMC by or on behalf of Dr Monro, which the Tribunal has taken into account.

Expert Witness Evidence

14. The Tribunal received evidence from a GMC expert witness, Dr E. Her initial expert report was dated 25 August 2023. Following receipt of further information she provided a supplementary report on 16 March 2024. Dr E was asked to give her opinion to assist the Tribunal in understanding the professional standards to be expected of a reasonably competent General Physician (specialising in Environmental Medicine). Dr E gave oral evidence to the Tribunal on 29 May 2024.

15. Within her report, Dr E provided details of her qualifications. She stated that she had 40 years' experience in paediatrics and held a basic medical degree (MB ChB, Edinburgh 1982), and the MRCP, which is a qualification recognising postgraduate training in paediatrics. Dr E stated that she also had a MD, which is a higher degree awarded after a period of research, namely a two and a half year research fellowship in HIV that led to the production of a thesis. She stated that she also undertook four years' subspeciality training in paediatric infectious diseases and immunology, in Britain and the USA.

16. Dr E was appointed in June 1994 to a consultant post in paediatric infectious diseases, immunology, and allergy at the Royal Hospital for Sick Children in Glasgow and an Honorary Senior Lecturer at the University of Glasgow. The hospital moved site in June 2015 to become

the Royal Hospital for Children. Dr E stated that, in this post, she is responsible for the care of children presenting with acute and complicated infection, receiving referrals from all over Scotland. She stated that she is also lead clinician for paediatric immunology in the Scottish Paediatric and Adolescent Infection and Immunology Network. Dr E's practice includes the clinical management of children with fungal infection and provision of advice to other clinicians responsible for the management of such children. She has published in fields including blood borne virus infection, meningococcal disease, meningitis, antimicrobial resistance, and immune deficiency. Her competencies in other aspects of children's medicine, especially respiratory medicine, are those of a general paediatrician. Dr E has no specialist training in adult general, occupational, or environmental medicine beyond undergraduate level.

Documentary Evidence

17. The Tribunal had regard to the documentary evidence provided by the parties. This evidence included, but was not limited to, the following:

- GMC complaints form dated 17 April 2023 by Patient A's father;
- Breakspear Child Medical Questionnaire completed by Patient A's parents dated 17 April 2020;
- Summary of Initial Consultation Letter from Dr Monro to Patient A's parents dated 3 August 2020;
- Various consultation and cost estimate correspondence in respect of the care for Patient A from Breakspear in 2020;
- Patient A's General Practitioner (GP) medical records; and
- Patient A's Breakspear medical records.

The Tribunal's Approach

18. In reaching its decision on the facts, the Tribunal has borne in mind that the burden of proof rests on the GMC and it is for the GMC to prove the Allegation. Dr Monro does not need to prove anything. The standard of proof is that applicable to civil proceedings, namely the balance of probabilities, i.e. whether it is more likely than not that the events occurred.

19. The Legally Qualified Chair (LQC) gave legal advice to the Tribunal. She reminded the Tribunal that it should take all of the evidence into account, assess whether there were inconsistencies and contradictions in the evidence, determine whether it considered the evidence credible and reliable, and then decide what weight to place upon that evidence.

20. The LQC stated that, in relation to Patient A's mother, the Tribunal must assess the reliability of her evidence. It should have regard to factors such as whether her account had been consistent throughout, whether it was internally consistent, the degree of detail she provided and its quality, whether she had any ulterior motive that may indicate a lack of candour, and/or any factors relating to her credibility. The LQC stated that the Tribunal must also consider whether any evidence it had heard was corroborated, particularly by any documentation, such as a medical record, statement, e-mail or note produced contemporaneously or in the weeks or months after the relevant incident.

21. The LQC stated that, in relation to Dr E, she had given evidence as an expert. Due to her expertise in the field of paediatric medicine, specifically infectious diseases, Dr E was entitled to give evidence and opinions to the Tribunal on matters of a specialist kind which are not expected to be within common knowledge. As with any other witness, it is the Tribunal's task to weigh her evidence, including any opinion she expressed, and to decide what it did accept and what it did not. The LQC stated that, when assessing Dr E's evidence, the Tribunal should take into account a series of factors including, for example, her qualifications, practical experience, any source material she had relied upon, and the extent and quality of the data on which her opinion was based.

22. The LQC stated that Dr E's evidence had not been specifically challenged in cross-examination as Dr Monro had not attended. The LQC stated that the Tribunal should be careful not to reject Dr E's evidence or opinion unless there was a proper basis for it to do so. However, the Tribunal is the final arbiter of the facts, and it must base its determination on the evidence as a whole, of which Dr E's expert evidence and opinion forms only a part. If the Tribunal does not accept Dr E's evidence, or any part of it, it must give reasons.

23. The Tribunal does not have to decide every factual point which has been put before it, only those which are relevant to determining whether each of the paragraphs of the Allegation is well founded. The LQC stated that the Tribunal will not be tempted to draw conclusions without reference to the evidence that it has heard and will not be drawn into speculation regarding matters that did not form part of the evidence or are unrelated to the Allegation.

24. The LQC stated that Dr Monro was not present at the hearing and the Tribunal had decided to proceed in her absence. The LQC stated that this would not be held against Dr Monro in any way. The LQC stated that this did not amount to any form of admission of any part of the Allegation and it cannot, and will not, be used in any way adverse to her during

the Tribunal's deliberations. The Tribunal will take account of all of the evidence before it, including the responses and comments provided by Dr Monro and XXX, Mr D. The LQC stated that the weight that the Tribunal will attach to those matters, given that they are not contained in a statement of truth, have not been given before the Tribunal under oath, and have not been tested by the GMC in cross-examination, was a matter for the Tribunal to determine.

The Tribunal's Analysis of the Evidence and Findings

25. The Tribunal has considered each paragraph of the Allegation separately and has evaluated the evidence in order to make its findings on the facts.

26. The Tribunal noted the written response to the Rule 15 Allegation from Dr Monro that was sent to the GMC on 12 April 2024. Within that letter, Dr Monro reiterated that she had taken the decision not to engage with the GMC any further. She stated that her membership of the GMC lapsed years ago, and that the GMC had accepted and acknowledged her decision to surrender her licence to practise but had twice refused her applications for voluntary erasure. Dr Monro stated that she was no longer a physician and consequently would not allow the GMC to impose itself on her or waste her time. She said that she was not subject to the GMC's procedures. Dr Monro stated that she had read the Allegation which she considered contained many factual inaccuracies *"and it also contains your opinions, or perhaps those of your expert witness, with which I disagree"*. Dr Monro provided a number of written responses to the Allegation.

27. Dr Monro went on to state:

> *"I think that the complete premise of this case is absurd. [Patient A's mother] presented a credible history when I initially spoke with her. My colleague Dr C could not find any significant signs or symptoms of ill health when she performed a limited examination of [Patient A]. She was also alarmed by some of [Patient A's mother]'s comments.*
>
> *We became increasingly concerned about her demands for strong and inappropriate medication for her daughter and her demands for letters that she wished to use to criticise her daughter's NHS medical team. [Patient A's mother] had also instructed a lawyer to sue other doctors.*
>
> *With this in mind, we reached the conclusion that [Patient A's mother] and perhaps her husband, were involved in Munchausen syndrome by proxy. Please see my letter to [Patient A]'s GP dated 16 November 2020.*

I have caused no harm to this child. I acted in her best interests at all times and I provided the best advice and guidance to her mother. If you believe that I fell short of the expected standards, I disagree. However, I will not engage any further."

Paragraph 1(a)(i) and (ii)

28. The Tribunal considered whether, between 30 April 2020 and 18 November 2020, Dr Monro was involved in the care and treatment of Patient A and failed to provide good clinical care in that she:

a. did not take an environmental history to establish whether there were any ongoing risks of exposure to fungal or other toxins in Patient A's environment, including from:

i. ongoing exposure to moulds;

ii. consumption of foods potentially high in Ochratoxin A ('OTA').

29. The Tribunal noted the submissions of Mr Hamlet that the GMC's case was principally based on the absence of any record of any discussion between Dr Monro and Patient A's mother as to whether the current environment in which Patient A was living indicated any ongoing risks of exposure to fungi/mould or toxins. Mr Hamlet stated that, whilst Patient A's mother first contacted Breakspear and approached Dr Monro on the basis that Patient A's symptoms were a product of her sucking mould from a rubber duck, it remained Dr Monro's duty as the clinician to make wider inquiry as to the possibility of other ongoing environmental factors.

30. The Tribunal had regard to the Breakspear Child Medical Questionnaire that Patient A's mother completed in respect of Patient A dated 30 April 2020. The Tribunal noted that there were some limited questions asked about the environment in which Patient A lived, and questions about the foods that Patient A was eating.

31. Dr Monro had a telephone consultation with Patient A's parents on 29 July 2020 and a clinic letter dated 3 August 2020 was sent to Patient A's mother. Under the heading 'Environment', the letter stated:

"She lives in the country near a main road. Her family home uses gas, but there are no coal fires and both parents are non-smokers."

This was a summary of the answers provided by Patient A's mother in the questionnaire. There is no evidence that anything further was discussed about Patient A's living conditions.

32. In the same clinic letter, Dr Monro also summarised information about Patient A's regular diet. There is nothing to indicate that the source of Patient A's food, her eating habits or diet were explored further in the telephone consultation.

33. The Tribunal was clear that Patient A's mother had contacted Breakspear regarding the specific incident where Patient A inhaled mould in her grandmother's bathroom after sucking on a rubber duck in early 2019, and the symptoms that Patient A had experienced since. Patient A's mother confirmed this in her oral evidence.

34. In Dr Monro's written response to the Rule 15 Allegation dated 12 April 2024, she stated that:

> [Regarding 1(a)(i)] *"This is incorrect: I discussed this with [Patient A's mother]. [Patient A's mother] demonstrated a deep anxiety about her family's exposure to mould and consequently I believed that she was doing a good job of avoiding mould exposure."*
>
> [Regarding 1(a)(ii)] *"This is incorrect: I discussed this with [Patient A's mother] and provided her with information about foods that might contain a high level of moulds."*

35. The Tribunal had regard to the expert report of Dr E, in which she stated:

> *"5.2.2. On the assumption that Dr Monro's claim of being a specialist in environmental medicine can be verified, failure to take an adequate environmental history to establish whether there were any ongoing risks of fungal or exposure to other toxins in [Patient A]'s environment. This can be expected to include ongoing exposure to moulds, for instance, in damp housing, hay lofts, old dilapidated buildings. However, given the most common mode of exposure to mycotoxins, enquiry into consumption of foods potentially high in OTA.*
>
> *5.2.2.1. This falls seriously below standard, because (even though the diagnosis of OTA toxicity was made based on an unvalidated test with an interpretation not based on scientific evidence) if exposure had been ongoing, attempts to remove the child from risks of exposure would have been the most important aspect of care. (GMP 16a)"*

and the supplementary expert report in which she stated:

"5.2.2.1: It is acknowledged that [Patient A's mother] understood that Dr Monro advised ongoing avoidance of mouldy and damp environments. However, given the most common source of OTA is food, my overall opinion is unchanged."

36. During Dr E's oral evidence, Mr Hamlet asked what details she would have expected Dr Monro to discuss with Patient A's parents about her current living environment. Dr E stated that she would have expected a detailed history of where Patient A might have been exposed to mould since the initial exposure in March 2019. Dr E noted a letter written by Dr Monro to the Great Plains Laboratory which provided some additional detail. This stated that the family had been in a water damaged house in 2019. Dr E's impression, however, was that this was gleaned from a discussion with Patient A's father, who had also consulted Breakspear about his health. She noted that there was nothing in the records which indicated a discussion relating specifically to Patient A. Dr E stated that she would have expected questions about Patient A's current living environment, like current building works at her home or damp, whether she was still visiting her grandmother's home, exploration of the possibility of exposure to mould as a result of her diet like exposure to mouldy cereals or whether she consumed food bought directly from farm outlets. Dr E stated that current environmental factors and food are such a crucial part of the history when exploring the possibility of mould exposure, she would have expected a record of such a discussion. She could find no record within the notes and, although Dr Monro asserted this had occurred, she provided no further detail.

37. The Tribunal was unable to find any record, beyond the original questionnaire, to show that there had been any conversation or consideration about any ongoing risks of exposure to fungal or other toxins in Patient A's environment. The Tribunal was clear, from Dr E's evidence, that Dr Monro should have taken an environmental history to establish whether there were any ongoing risks of exposure and taken this into account when formulating a treatment plan. There was discussion between Dr Monro and Patient A's mother that they should avoid water damaged buildings, but there was no specific reference to Patient A's home environment and diet.

38. The Tribunal also took account of the oral evidence of Patient A's mother who told the Tribunal that she did not have conversations with Dr Monro about whether Patient A was exposed to mould in her living environment or through her diet. The Tribunal noted that this evidence was consistent with the absence of anything being recorded in Patient A's medical records, suggesting that these issues had not been explored with her. The Tribunal also noted that there was no reference to consideration to environmental factors in the correspondence with Patient A's GP.

39. The Tribunal appreciated that the exploration of environment history, including foods, may not have been asked as part of the history in the first telephone conversation. Even after receipt of the results of the Mycotoxin test, however, the Tribunal could find no evidence of environmental history or status or diet being explored given that the test results could only be consistent with recent exposure and could not reflect exposure on a single occasion in March 2019. Given the reason for Patient A's mother to have sought Dr Monro's opinion, and the results of the Mycotoxin test as understood by Dr Monro, and based upon the opinion expressed by Dr E, the Tribunal was of the view that Dr Monro was under a duty to obtain an environmental history at least from that point.

40. The Tribunal determined that, on the balance of probabilities, it was more likely than not that Dr Monro failed to provide good clinical care in that she did not take an adequate environmental history to establish whether there were any ongoing risks of exposure to fungal or other toxins in Patient A's environment. Accordingly, the Tribunal found paragraph 1(a)(i) and (ii) of the Allegation proved.

Paragraph 1(b)(i) and (ii)

41. The Tribunal considered whether, between 30 April 2020 and 18 November 2020, Dr Monro was involved in the care and treatment of Patient A and failed to provide good clinical care in that she:

b. did not ensure an examination of Patient A's:

i. pulse rate and blood pressure;

ii. abdomen;

was carried out.

42. The Tribunal had regard to Dr Monro's clinic letter dated 3 August 2020 following the telephone consultation with Patient A's mother on 29 July 2020. The medical history includes reference to Patient A having had a bronchoscopy and other examinations regarding respiratory issues. It also included a large bullet point list of Patient A's symptoms, including constipation, headaches, dizziness, unexplained brown bruises on the body, mood swings, shortness of breath, and gastrointestinal problems.

43. The Tribunal took account of Dr C's record of the physical examination of Patient A undertaken on 10 September 2020 following the first telephone consultation with Dr Monro. At the top of that record, Dr C had written:

> *"Mother concerned about Covid-19 + requested I do a limited examination. Mother also reported that [Patient A] tells her that she sees dead family members."*

She had also recorded, by completion of a tick box, that Patient A's pulse was 'regular', but no pulse rate was recorded. In terms of blood pressure, Dr C had made the note *"Deferred - no paediatric cuff"*. In the 'Abdomen' section, Dr C had made the note *"Deferred"*.

44. In a letter dated 22 September 2020, Dr C stated that she had seen Patient A in the outpatient clinic on 10 September 2020. She reiterated the comments on the top of the record of examination, including that Patient A's mother was concerned about Covid-19 and requested a limited examination for Patient A.

45. In her written response to the Rule 15 Allegation dated 12 April 2024, Dr Monro stated that:

> *"Dr C reported that [Patient A's mother] insisted on a limited examination of her daughter because she was very anxious to avoid the potential risk of COVID-19 contagion… This was not possible because [Patient A's mother] refused to allow Dr C to perform a full examination of her daughter."*

46. The Tribunal had regard to the expert report of Dr E, in which she stated:

> *"3.3. All diagnoses in paediatrics are diagnosed on the basis of a full and comprehensive history, and a full physical examination.*
> *…*
> *There is no evidence that Dr Monro took an adequate paediatric or environmental history, conducted an adequate examination or formed an adequate differential diagnosis.*
> *…*
> *4.3.10. Failure to ensure that the examination performed was adequate to explore the differential diagnosis of the presenting symptoms*
> *4.3.10.1. No pulse rate or BP – important to explore symptoms such as dizziness, grey skin, fatigue, headaches*
> *4.3.10.2. No abdominal examination despite many gastrointestinal symptoms*
> *…*

> *4.3.10.5… Some of her symptoms would be compatible with CNS disease (headache, vomiting, photophobia), cardiovascular disease (dizziness, grey skin, fatigue), chronic infection or inflammatory process, or malignancy.*
>
> *…*
>
> *5.2.4. Dr Monro failed to take into account the adequacy of the examination before making conclusions based on the findings.*
>
> *5.2.4.1. This fell seriously below standard of care because the child presented with abdominal symptoms among others, and therefore examination of the abdomen was essential in order to make an appropriate differential diagnosis (GMP 16a)."*

and in the supplementary expert report:

> *"5.2.4.1: The examination of the abdomen and blood pressure and pulse rate was essential in order to make an appropriate differential diagnosis based on all the presenting symptoms."*

47. During Dr E's oral evidence, Mr Hamlet asked what an abdominal examination should consist of in this particular context. Dr E stated that it should include an inspection, such as looking for any scars or abnormalities, and whether the abdomen looked distended. She stated that the doctor would palpate the stomach to see if there was evidence of any tenderness and feeling for masses or enlarged organs. The doctor would also listen with their stethoscope to see whether the bowel sounds were normal. Dr E stated that the purpose of the abdominal examination was to see whether there was any pathology related to the symptoms set out by Patient A's mother. She stated that she would expect a full examination, including abdominal examination, to have taken place before Dr Monro was able to come to any conclusions about diagnosis.

48. Dr C's record of the physical examination of Patient A was shown to Patient A's mother for the first time during her oral evidence to the Tribunal. Patient A's mother recalled that Dr C had put a monitor on Patient A's finger and said that an abdominal examination had been carried out. She was asked about the notes that Dr C had made at the top of the examination record. Patient A's mother said that she did not request a limited examination or say that Patient A saw dead family members. She did, however, say that she had psychic abilities herself but denied that she had said anything about this in reference to her daughter.

49. The Tribunal placed greater weight on the contemporaneous record completed by Dr C rather than the evidence of Patient A's mother in this instance. The Tribunal appreciated that Patient A's mother was recalling events some four years ago, and in circumstances where Patient A had had several other medical appointments around this time. The Tribunal

also considered that Patient A's mother may have been less than candid for fear of criticism. The Tribunal did not regard the reference to conversation with dead relatives as coincidental given Patient A's reference to her own psychic abilities and therefore concluded that this had been said, which supported its conclusion about the accuracy of the medical records.

50. The Tribunal found that Dr Monro relied upon Dr C's examination record. This examination record showed that parts of the physical examination, which Dr E considered necessary, had not been carried out. The Tribunal had regard to the wording of this paragraph of the Allegation, including *"did not ensure an examination"*. It considered that this paragraph placed the onus upon Dr Monro to ensure that the examinations were carried out to ensure good clinical care. The Tribunal relied on Dr E's evidence that the missing elements of the physical examination were necessary to assist Dr Monro to make a proper diagnosis of Patient A, especially given the extent and seriousness of Patient A's symptoms.

51. The Tribunal found that there was no record that Dr Monro recognised that there were deficiencies in the physical examination of Patient A. It further found that she had not spoken with Patient A's parents, explained the importance of the missing elements of the physical examination, and arranged for these elements to be undertaken.

52. The Tribunal determined that, on the balance of probabilities, it was more likely than not that Dr Monro failed to provide good clinical care in that she did not ensure an examination of Patient A's pulse rate, blood pressure and abdomen was carried out. Accordingly, the Tribunal found paragraph 1(b)(i) and (ii) of the Allegation proved.

Paragraph 1(c)

53. The Tribunal considered whether, between 30 April 2020 and 18 November 2020, Dr Monro was involved in the care and treatment of Patient A and failed to provide good clinical care in that she:

> *c. did not make an appropriate differential diagnosis based on the presenting symptoms.*

54. The Tribunal had regard to Dr Monro's clinic letter dated 3 August 2020 following the telephone consultation she had with Patient A's mother on 29 July 2020. That included a large bullet point list of Patient A's symptoms, including constipation, headaches, dizziness, unexplained brown bruises on the body, mood swings, shortness of breath, and gastrointestinal problems.

55. The Tribunal noted the submissions of Mr Hamlet that the GMC's case was that Dr E highlighted that Dr Monro had not recorded a differential conclusion on the basis of the history or physical examination that were taken. Mr Hamlet stated that Dr Monro appeared to look for evidence to support Patient A's mother's belief that Patient A's symptoms had arisen as a result of ingestion of mould.

56. In Dr Monro's written response to the Rule 15 Allegation dated 12 April 2024, she stated that:

> *"This is incorrect. In my letter dated 3 August 2020, I recorded the comprehensive history that I had taken from [Patient A's mother] and of course I would not have made a diagnosis until the child had been examined."*

57. The Tribunal had regard to the expert report of Dr E, in which she stated:

> *"3.3. All diagnoses in paediatrics are diagnosed on the basis of a full and comprehensive history, and a full physical examination.*
> *…*
> *There is no evidence that Dr Monro took an adequate paediatric or environmental history, conducted an adequate examination or formed an adequate differential diagnosis.*
> *…*
> *4.3.10.5. No documented definitive conclusion on the basis of the history and examination, nor any differential diagnosis, nor any attempt to arrange tests based on this differential diagnosis. Given the extensive and varied nature of the symptoms reported, this differential is extremely wide. It would be standard practice to review diagnoses already considered by the professionals previously involved in care, and which may previously have been excluded, and reasonable, having done this, not to repeat all previously performed tests. Some of her symptoms would be compatible with CNS disease (headache, vomiting, photophobia), cardiovascular disease (dizziness, grey skin, fatigue), chronic infection or inflammatory process, or malignancy. However, it is accepted that despite the multitude of symptoms described, she appeared well and lively. Psychological or non-organic aetiologies should therefore also have been considered.*
> *…*
> *5.1.3. Failure to document a differential diagnosis, reasoning behind investigations and treatment recommended, and information given to parents.*

58. In Dr E's oral evidence, she referred to the long list of symptoms reported by Patient A's mother. Dr E stated that, when seeing a child with so many concerning symptoms, a practitioner would certainly want to think more widely in terms of differential diagnoses. She

stated that, practically, she could spend hours setting out all the possible diagnoses but that her real criticism was not that this had not been done, but that Dr Monro seemed to be focused on confirming the belief presented to her by the mother. Dr E stated that it was always important to consider the parental opinion as part of the total assessment but, at the same time, also consider other possibilities as temporal relationships between an event and the appearance of symptoms were not always causal relationships. Serious diagnoses could be missed unless alternative possibilities were considered.

59. The Tribunal was told by Dr E that she could not think of a differential diagnosis that would incorporate all of Patient A's symptoms as they related to all systems of the body. There appeared to be a wide range of possible diagnoses.

60. The Tribunal accepted Dr E's opinion that Dr Monro was led by Patient A's mother, who was seeking confirmation that the mould from the rubber duck incident was the cause of Patient A's symptoms. The Tribunal noted, however, that because of the multitude of symptoms there was such a wide range of possibilities that it was not realistic for Dr Monro to have recorded every potential diagnosis and to have done so would have been meaningless. Moreover, it would not have advanced a proper understanding of Patient A's case. Dr E did not tell the Tribunal what, realistically given her own evidence, she expected Dr Monro to have recorded by way of differential diagnosis. The Tribunal considered that this paragraph of the Allegation did not accurately capture the conduct criticised by Dr E.

61. The Tribunal determined that, on the balance of probabilities, that Dr Monro did not fail to provide good clinical care by not making an appropriate differential diagnosis based on the presenting symptoms. Accordingly, the Tribunal found paragraph 1(c) of the Allegation not proved.

Paragraph 1(d)

62. The Tribunal considered whether, between 30 April 2020 and 18 November 2020, Dr Monro was involved in the care and treatment of Patient A and failed to provide good clinical care in that she:

> *d. arranged investigation by Mycotoxin urine test ('the Test') which was inappropriate to explore the possibility of illness due to fungal infection.*

63. In Dr Monro's written response to the Rule 15 Allegation dated 12 April 2024, she stated that:

"This is incorrect. This test that I recommended is one of many concerning the assessment of illness consequent to mould exposure. I also recommended a number of other tests that [Patient A's mother] declined to undertake."

64. The Tribunal had regard to the expert report of Dr E, in which she stated:

"3.1. Fungi such as aspergillus are ubiquitous in the environment, and therefore all children are exposed to them from an early age. High risk environments include buildings which are damp, recent building works, and those with rotting vegetation (eg leaves in autumn). They can cause invasive disease in children who are immunocompromised, or rarely in other chronic conditions, such as diabetes. Moulds can also trigger immunological responses, the commonest being in allergic diseases such as rhinitis, and asthma. Rarely they can trigger inflammation in the lung leading to interstitial lung disease (eg "farmer's lung"). The possibility of allergy to moulds had been investigated and excluded, as had fungal pulmonary disease. The rest of [Patient A]'s symptoms and signs were not compatible with a diagnosis of fungal disease in the immunocompetent.

3.2. Fungi produce mycotoxins which can contaminate food during storage. One such is ochratoxin A (OTA). The majority of studies detail the risks from ingestion, and this is the only context in which WHO describes potential toxicity. However, exposure through inhalation by working continually in water damaged buildings has been described. No risk from an isolated exposure to mould has been described. Toxicity of OTA in animals is well described and includes renal disease and carcinogenesis. OTA has been implicated in various human nephropathies, and its carcinogenic and immunotoxic effects have been described in animals, but this has not been proven in humans. No other medical conditions have any proven association with exposure to OTA. Although only slowly metabolized, blood and urine levels fall once the person is no longer exposed. Toxic levels would therefore not be expected following an isolated exposure many months or years previously. While blood and urine levels have been measured using a variety of techniques, this is on a research basis. They have been used to explore an association with various medical conditions. They are however, not diagnostic tests for a recognised specific disease or disease process.
…
3.3… As detailed above, urine tests for mycotoxins are not validated for diagnostic purposes. Moreover, the presence of mycotoxins would not indicate fungal disease, or to allergy induced by inhaled fungal spores, but rather chronic exposure to the toxic products of fungi, most commonly, as detailed above through ingestion of contaminated food.
…
4.3.12.1.4. Mycotox urine test is not a validated test for diagnosis of clinical disease, as detailed in paragraph 3.3. It was therefore neither appropriate nor meaningful.
…
Seriously below:

…
5.2.5. Dr. Monro arranged investigations which were inappropriate to explore the possibility of illness due to exposure to fungi, namely the Mycotox urine test."

and in the supplementary expert report:

> *"5.2.5: Appropriate tests for exploration of the possibility of fungal infection, or allergy resulting from environmental exposure to fungi are outlined in section 3.3. OTA is a toxin produced by the fungi aspergillus and penicillium. High levels may be found in urine from people who had ingested a large amount of food heavily contaminated by fungi over a long period of time, or, exceptionally, been chronically exposed to an extremely mouldy environment such a water damaged building. This was not the history given. The family's concern was that Patient A's current symptoms were due to a specific incident which occurred many months ago, when she had drunk/inhaled mouldy water from a toy duck, in the absence of any history gleaned of ongoing exposure to environmental mould. Any test for mycotoxins would therefore not have been appropriate, even had the laboratory been accredited to perform and interpret this test..."*

65. The Tribunal noted that Patient A's mother advised Dr Monro that Patient A had a lengthy list of symptoms and wanted advice and a diagnosis. The Tribunal heard from Dr E that the test that Dr Monro suggested was *"not a validated test for diagnosis of clinical disease"* and that the diagnosis could not be made using a test employment for research purposes only. The Tribunal concluded that the test provided no benefit with regard to Patient A's clinical care.

66. In addition, the Tribunal was conscious that Patient A's parents had sought the referral due to the rubber duck incident in March 2019. In oral evidence, Dr E stated that as the exposure was an isolated incident which occurred around 18 months before the test was undertaken, even if she had been exposed to mycotoxin as a result, this would not still be present 18 months later. As no other event had been identified which could have resulted in exposure to mycotoxin the Tribunal concluded that the urine test was neither appropriate nor meaningful.

67. The Tribunal determined that, on the balance of probabilities, it was more likely than not that Dr Monro failed to provide good clinical care in that she arranged investigation by the Test, which was inappropriate to explore the possibility of illness due to fungal infection. Accordingly, the Tribunal found paragraph 1(d) of the Allegation proved.

<u>Paragraph 1(e)</u>

68. The Tribunal considered whether, between 30 April 2020 and 18 November 2020, Dr Monro was involved in the care and treatment of Patient A and failed to provide good clinical care in that she:

e. did not record the relevance of the Test results to Patient A's condition and treatment.

69. The Tribunal had regard to Dr Monro's letter dated 5 October 2020, following the telephone consultation she had with Patient A's mother on 1 October 2020, which included:

"I had the opportunity of speaking to [Patient A's] mother on the telephone, on the 1st [October] 2020.

We discussed the results of an investigation she had undertaken, which is attached and summarised below.

MycoTox (Great Plains, 10/09/2020, Req: 840226)

This showed the presence of:

- *Ochratoxin A (OTA) at 52.10ng/g creatinine (NR: 7.5). This is a nephrotoxic, immunotoxic, and carcinogenic mycotoxin. This chemical is produced by molds in the Aspergillus and Penicillium families. Exposure is primarily through inhalation in water-damaged buildings. Exposure to OTA can also come from contaminated foods such as cereals, grape juices, dairy, spices, wine, dried vine fruit and coffee. OTA can lead to kidney disease and adverse neurological effects. Studies have shown that OTA can cause significant oxidative damage to multiple brain regions and the kidneys. Dopamine levels in the brain of mice have been shown to be decreased after exposure to OTA.*

- *It also showed a small amount of Citrinin (Dihydrocitrinone DHC) at <25.00 ng/g creatinine (NR: <25).*

Summary & Recommendations:

I suggested that she could have colestyramine, which helps to trap bile and clear away the mycotoxins, but she would need vitamins A, D and E, as well as essential fats, if this were to be undertaken.

However, because she is only five years old, it may be that taking a very small dose of Yaeyama Chlorella powder (1/4 teaspoon daily), might be helpful preferentially and this was suggested to [Patient A's mother]."

[*Colestyramine and Cholestyramine are the same drug]*

70. In Dr Monro's written response to the Rule 15 Allegation dated 12 April 2024, she stated that:

"This incorrect. [Patient A's mother] was provided with detailed literature and information about every test."

71. The Tribunal noted the submissions of Mr Hamlet that the GMC's case was based upon Dr E's expert opinion. Mr Hamlet stated that the information around the Test results was complex and should have been explained to Patient A's parents, in appropriate language and how the result was significant in relation to Patient A's presenting symptoms. Mr Hamlet said that the manner in which the results were communicated to Patient A's parents, effectively a cut and paste from the Laboratory information sheet without more explanation, indicated that Dr Monro herself did not understand their relevance.

72. The Tribunal had regard to the expert report of Dr E, in which she stated:

"4.4. The clinical record and letter resulting from the telephone consultation of 01/10/2020, which was copied to the mother, gives the report of the Mycotox test. No specific named diagnosis is mentioned. The letter implies that 2 results (OTA and citrinin) were abnormal, which is an inaccurate reflection of the report, which quotes only OTA above their reference range. There is no record of the discussion had regarding the interpretation of the result, but half of the laboratory interpretation is quoted in the letter. This is complex information, and it would be usual practice either to discuss the results verbally with the patient and family, or to explain in written correspondence in appropriate language the doctor's interpretation of the significance of the result, and how it relates to the condition suffered by the patient. The information contained in the report does not reflect that of the published scientific literature, as detailed above. There is no evidence of Dr Munro interpreting the result in the light of [Patient A]'s presenting symptoms nor the scientific literature…"

73. The Tribunal was unable to find any record explaining why the Test was being done given the history, or the rationale for it. The Tribunal was concerned that it appeared that Dr Monro had not understood that the Test was not diagnostic. The Tribunal was clear that Dr Monro did not say in the clinic letter of 5 October 2020 that what was found was causing Patient A's symptoms, which symptoms were caused by the findings and how this should be

treated. The Tribunal concluded, however, that Patient A's mother (understandably) concluded that the Test results confirmed that ingestion of water from the duck had introduced mycotoxins into Patient A's body which had caused her symptoms.

74. The Tribunal determined that because Dr Monro did not herself understand what the Test results meant, she simply passed on part of the information contained in the Test result to Patient A's mother and left it to her to draw her own conclusions. The Tribunal accepted Dr E's evidence that there was *"no evidence of Dr Munro interpreting the result in the light of [Patient A]'s presenting symptoms nor the scientific literature"*. The Tribunal was unable to find any analysis of the Test results by Dr Monro and no record of the relevance of them to Patient A's condition and treatment.

75. The Tribunal determined that, on the balance of probabilities, it was more likely than not that Dr Monro failed to provide good clinical care in that she did not record the relevance of the Test results to Patient A's condition and treatment. Accordingly, the Tribunal found paragraph 1(e) of the Allegation proved.

Paragraph 1(f)(i)

76. The Tribunal considered whether, between 30 April 2020 and 18 November 2020, Dr Monro was involved in the care and treatment of Patient A and failed to provide good clinical care in that she:

> *f. provided information to Patient A's parents based on the Test's laboratory report ('the Report'):*
>
> > *i. which asserted that the Test was done in a ~~CILA~~ CLIA approved laboratory before verifying that it was accredited.*

77. The Tribunal had regard to a letter from Dr Monro to Patient A's mother dated 28 October 2020 in which she stated:

> *"I have written to [Patient A]'s doctor a "To Whom It May Concern" letter… with the results of the Great Plains MycoTox reports. They will be able to see that the laboratory which produced the reports is accredited by the CLIA in the United States and that Breakspear Medical has CQC registration. The doctors here are all on the General Medical Council register…"*

78. In Dr Monro's written response to the Rule 15 Allegation dated 12 April 2024, she stated that the laboratory was CLIA accredited.

79. The Tribunal noted the submissions of Mr Hamlet that the GMC's case was that, although the Laboratory was approved by the CLIA, Dr Monro had now evidence that the Test had been accredited by it. Mr Hamlet submitted that the words *"accredited"* and *"approved"* could be used interchangeably. He further submitted that Dr Monro had asserted the Laboratory was approved before she had established that the particular tests was CLIA approved. Mr Hamlet submitted that this was relevant in terms of Dr Monro informing Patient A's parents about the limitations of those tests and that they, in terms of the bigger picture, did not meet certain standards.

80. Mr Hamlet accepted, however, that the GMC had not produced any information about the CLIA or its ambit.

81. The Tribunal had regard to Dr E's qualifications and area of expertise. It also had regard to her report in which she stated:

> *"2.16.16. [44] Dr Monro emailed "BS", director, Great Plains Laboratory on 19th November 2020 asking for evidence of validation of the tests performed by Great Plains Laboratory. No reply is documented.*
> *…*
> *5.2.5… Dr Monro asserted that the tests were done in a CLIA approved laboratory, before verifying that these particular tests were accredited."*

82. The Tribunal noted that in oral evidence, when asked what the acronym CLIA stood for, Dr E was unable to answer. Further Dr E accepted that she had no expertise in the regulatory framework operating in the US or indeed in the U.K.. Dr E was frank in acknowledging that she did not know how the CLIA accreditation operated and whether this was confined to Laboratories or also included individual tests. She stated that a laboratory specialist would know but that her understanding was that physicians in the United States would always send to CLIA approved laboratories.

83. The Tribunal had regard to the wording of this paragraph of the Allegation. It concluded that 'approved' and 'accredited' are not synonymous. The Tribunal concluded that there was insufficient evidence for it to be satisfied that the CLIA had any role in approving or accrediting individual tests and that, reading Dr E's report carefully, she appeared to be referring to the literature from the Great Plains Laboratory which related to approval of the test by the FDA not the CLIA.

84. The Tribunal further noted that a possible interpretation of Dr Monro's email to The Great Plains Laboratory asking for evidence of the validation of the Test was not that she did not understand it to be accredited/approved by the CLIA but rather than she wanted documentary proof to pass on to others. The Tribunal noted that this email was written after Dr Monro's use of the Test had been criticised. The Tribunal did not accept that the only proper inference from this email was that at the time she recommended use of the test she did not know that it was not CLIA approved.

85. For all the reasons set out above, the Tribunal determined that there was insufficient evidence on which it could conclude that it was more likely than not that this paragraph of the Allegation was proved. Accordingly, the Tribunal found paragraph 1(f)(i) of the Allegation not proved.

Paragraph 1(f)(ii)

86. The Tribunal considered whether, between 30 April 2020 and 18 November 2020, Dr Monro was involved in the care and treatment of Patient A and failed to provide good clinical care in that she:

> *f. provided information to Patient A's parents based on the Test's laboratory report ('the Report'):*
>
> *…*
>
> *ii. by providing an incomplete transcript of the Report without clinical context.*

87. The Tribunal had regard to the expert report of Dr E, in which she stated:

> *"[Dr Monro] provided an incomplete transcript of the laboratory report to the parents without clinical context, the content of which would have been expected to be alarming. She ought to have explained these results in simple language, relating how a toxic level might have led to the symptoms [Patient A] was experiencing."*

88. The Tribunal noted that the transcript of the laboratory report was provided to Patient A's mother in full. It also noted that Patient A's mother had been provided with literature from the Great Plains Laboratory well in advance of the Test being performed which stated that the Laboratory was based in the US and that the Test was not approved by the Food and Drug Administration (FDA).

89. The Tribunal had regard to Dr Monro's letter dated 5 October 2020, following the telephone consultation she had with Patient A's mother on 1 October 2020, which has been quoted above. The Tribunal considered that despite provision of the full report under the same cover, it is the responsibility of a competent doctor to evaluate the test result and then explain it in clear terms to non-medically trained members of the public. It is not the responsibility of the patient or their representative to interpret this result.

90. The Tribunal found that the letter provided a section of the report without explaining its relevance to the clinical context. The Tribunal took into account the evidence of Patient A's mother that she was left with the understanding that the rubber duck incident had caused the high level of mycotoxins found and that as a result Patient A required treatment for illness arising from mould exposure. As Dr E's report made clear, this conclusion was wholly incorrect.

91. The Tribunal determined that, on the balance of probabilities, it was more likely than not that Dr Monro failed to provide good clinical care in that she provided information to Patient A's parents based on the Report by providing an incomplete transcript of the Report without clinical context. Accordingly, the Tribunal found paragraph 1(f)(ii) of the Allegation proved.

Paragraph 1(f)(iii)(1) to (6)

92. The Tribunal considered whether, between 30 April 2020 and 18 November 2020, Dr Monro was involved in the care and treatment of Patient A and failed to provide good clinical care in that she:

> *f. provided information to Patient A's parents based on the Test's laboratory report ('the Report'):*
>
> *…*
>
> *iii. without alerting them to:*
>
> *1. the limitations of the Test;*
>
> *2. the fact that it was performed in a laboratory that did not conform to NHS standards;*
>
> *3. the fact that it was not approved in the United States;*
>
> *4. which (if any) of the toxic effects outlined in the Report had been experienced by Patient A;*

5. whether any further investigations were necessary to explore the possibility of such toxic effects;

6. how further exposure could be prevented.

93. In Dr Monro's written response to the Rule 15 Allegation dated 12 April 2024, she stated that:

"[Patient A's mother] had declined to proceed with all of the investigations I suggested, but I did provide both verbal and written explanation of the implications and relevance of the test results. We do not operate within the NHS and consequently we are not limited to the NHS laboratory tests."

94. The Tribunal had regard to the expert report of Dr E, in which she stated:

"5.2.5. She provided information on the basis of these tests to parents without discussion of the limitations of the test or making an assessment of their interpretation in the specific clinical context. She provided an incomplete transcript of the laboratory report to the parents without clinical context, the content of which would have been expected to be alarming. She ought to have explained these results in simple language, relating how a toxic level might have led to the symptoms [Patient A] was experiencing. She should have made it clear that these tests were performed in a laboratory that did not conform to the standards required by those performed in the NHS, and the tests were not approved in the United States, where they were performed. Even if the results were considered by her at the time to have any validity, given the risks of toxicity outlined in the report (chiefly nephrotoxicity, immunotoxicity, carcinogenicity, and neurological effects), and she believed that [Patient A] had suffered toxicity, she should have discussed which, if any of these toxic effects had been experienced by [Patient A], whether any further investigations were necessary to explore the possibility of such effects, and how further exposure could be prevented. If she believed that [Patient A] had not suffered such toxicity, she should have reassured the family, and explained the reason for needing treatment.

5.2.5.1. This fell seriously below standard of care as investigation and advice given was not based on the best available evidence, and the manner of its communication would be expected to cause pain and distress to the parents…"

95. With regard to paragraph 1(f)(iii)(1) of the Allegation, the Tribunal had regard to Dr E's expert opinion, including that Dr Monro had provided information to Patient A's parents *"without discussion of the limitations of the test or making an assessment of their interpretation in the specific clinical context"*. The Tribunal understood that the primary limitation of the Test was that it was not diagnostic. The Tribunal accepted the written and oral evidence of Patient A's mother that they had limited funds available, and that Dr Monro

had advised them that this was the best Test to spend their money on. The Tribunal was of the view that the parents had understood the Test to be diagnostic, which was not the case.

96. The Tribunal determined that, on the balance of probabilities, it was more likely than not that Dr Monro failed to provide good clinical care in that she provided information to Patient A's parents based on the Report without alerting them to the limitations of the Test. Accordingly, the Tribunal found paragraph 1(f)(iii)(1) of the Allegation proved.

97. In respect of paragraphs 1(f)(iii)(2) and (3) of the Allegation, the Tribunal had regard to Dr E's expert evidence as quoted above. It was also mindful of her oral evidence in which she was clear about the limits of her expertise in terms of the regulatory framework in the United States. The Tribunal noted that Patient A's parents were sent The Great Plains Laboratory literature, which set out that it was a test performed in the United States and was not approved by the FDA.

98. The Tribunal was unable to find any evidence before it that the laboratory did not confirm to NHS standards, and it was unclear about whether the approval in the United States should have come from the FDA or another body. Simply, the Tribunal not been provided with information about the regulatory processes surrounding laboratory testing in the United States.

99. The Tribunal determined that, on the balance of probabilities, it was not more likely than not that Dr Monro failed to provide good clinical care in that she provided information to Patient A's parents based on the Report without alerting them to the fact that it was performed in a laboratory that did not conform to NHS standards or that it was not approved in the United States. It concluded, based on the evidence before it, that the GMC had not discharged the burden of proof upon it and, given Dr E's comments as to the limits of her expertise, it would not have been appropriate to rely on her evidence in this regard. Moreover, the Tribunal also noted that in her evidence, Patient A's mother was unable to say whether she would have agreed to the test knowing of this limitation. Finally, the Tribunal concluded that Patient A's mother was guarded in her responses about what literature she had read before the Test was undertaken. The Tribunal found Patient A's mother to be intelligent with a good level of literacy. The literature from the Great Plains laboratory was clear that it was based in the US and the Tribunal were satisfied that Patient A's mother would have appreciated this. Accordingly, the Tribunal found paragraphs 1(f)(iii)(2) and (3) of the Allegation not proved.

100. With regard to paragraph 1(f)(iii)(4) of the Allegation, the Tribunal had regard to Dr Monro's letter dated 5 October 2020 to Patient A' parents, which has been quoted above. This included that: *"Studies have shown that OTA can cause significant oxidative damage to multiple brain regions and the kidneys"*. The Tribunal had regard to Dr E's expert evidence as quoted above. The Tribunal determined that, as with paragraph 1(f)(ii), the letter provided a section of the report without explaining its relevance to the clinical context. There was no analysis and no explanation by Dr Monro of what the results meant. The wording copied from the Report included quite alarming possible effects of OTA and there was no link made by Dr Monro between the results and anything experienced by Patient A. The Tribunal noted that Patient A's parents went to Patient A's GP with this letter, said that she had received the diagnosis from Dr Monro, and asked for the medication for her daughter. The NHS Consultant Paediatrician raised concerns as a result.

101. The Tribunal determined that, on the balance of probabilities, it was more likely than not that Dr Monro failed to provide good clinical care in that she provided information to Patient A's parents based on the Report without alerting them to which (if any) of the toxic effects outlined in the Report had been experienced by Patient A. Accordingly, the Tribunal found paragraph 1(f)(iii)(4) of the Allegation proved.

102. In respect of paragraph 1(f)(iii)(5) of the Allegation, the Tribunal had regard to Dr E's expert evidence as quoted above. The Tribunal noted Dr E's opinion that the Test was neither appropriate nor meaningful and that the methodology was flawed. The Tribunal determined that suggesting that Dr Monro had failed to alert Patient A's parents to whether any further investigations were necessary, on the basis of a flawed test, was irreconcilable. For completeness, there was no indication before the Tribunal of what other investigations might have been necessary to explore this in any event.

103. The Tribunal determined that, on the balance of probabilities, it was not more likely than not that Dr Monro failed to provide good clinical care in that she provided information to Patient A's parents based on the Report without alerting them to whether any further investigations were necessary to explore the possibility of such toxic effects. It concluded, based on the evidence before it, that the GMC had not discharged the burden of proof upon it. Accordingly, the Tribunal found paragraph 1(f)(iii)(5) of the Allegation not proved.

104. With regard to paragraph 1(f)(iii)(6) of the Allegation, the Tribunal again had regard to Dr Monro's letter dated 5 October 2020 to Patient A' parents, which has been quoted above. This included the section from the Report about the OTA results, as copied from The Great Plains Laboratory test results.

105. The Tribunal had regard to the witness statement of Patient A's mother, in which she stated:

> *"She also told us that in order to prevent further exposure that we had to keep [Patient A] our of water damaged or damp buildings, and that we would have to move if we were in a water damaged building."*

106. The Tribunal was of the view that Dr Monro had provided some information to Patient A's parents but not the full picture. The Tribunal understood that, if from Dr Monro's perspective in having concluded that Patient A had been exposed to mycotoxins and thinking this was responsible for at least some of Patient A's symptoms, she should have clearly set out how to prevent further exposure to moulds in the 5 October 2020 letter. It was clear that, if this had been the case, Patient A's parents would have needed to ensure that Patient A avoided water damaged buildings but also, crucially, that she should avoid exposure to mouldy foods. The Tribunal determined that Patient A's mother had been alerted to only one means by which future exposure could be prevented. This means that the risk of further exposure would have remained.

107. The Tribunal determined that, on the balance of probabilities, it was more likely than not that Dr Monro failed to provide good clinical care in that she provided information to Patient A's parents based on the Report without alerting them to how further exposure could be prevented. Accordingly, the Tribunal found paragraph 1(f)(iii)(6) of the Allegation proved.

Paragraph 1(f)(iv)(1) and (2)

108. The Tribunal considered whether, between 30 April 2020 and 18 November 2020, Dr Monro was involved in the care and treatment of Patient A and failed to provide good clinical care in that she:

> *f. provided information to Patient A's parents based on the Test's laboratory report ('the Report'):*
>
> *…*
>
> *iv. which, in the alternative to paragraph 1.f.iii, having alerted them to the features set out in paragraph 1.f.iii and believing that Patient A did not have toxicity, you failed to:*
>
> *1. reassure Patient A's parents;*
>
> *2. explain the reason for needing treatment.*

109. The Tribunal had regard to the wording of paragraph 1(f)(iv) of the Allegation and to its findings at paragraph 1(f)(iii) as set out above.

110. The Tribunal has found paragraphs 1(f)(iii)(1), (4), and (6) proved it did not go on to consider paragraph 1(f)(iv) of the Allegation in those respects, which are allegations in the alternative.

111. The Tribunal has found paragraphs 1(f)(iii)(2), (3) and (5) not proved. In terms of paragraph 1(f)(iv) of the Allegation, the Tribunal was being asked to consider a situation where Dr Monro believed that Patient A did not have toxicity. The Tribunal was clear that Dr Monro believed that the Test was to establish whether there was toxicity. The Tribunal also found that Dr Monro believed that the results of the Test demonstrated this. It concluded that the fundamental issue is that Dr Monro did not properly understand the Test or the results and lacked the expertise to recognise, as Dr E identified, that in addition to the result not being diagnostic, the methodology applied was fundamentally flawed.

112. Given the findings that the Tribunal has made in respect of paragraph 1(f)(iii) of the Allegation, it would be illogical to consider the alternative at paragraph 1(f)(iv). The Tribunal therefore did not consider this paragraph as it was drafted in the alternative.

Paragraph 1(g)

113. The Tribunal considered whether, between 30 April 2020 and 18 November 2020, Dr Monro was involved in the care and treatment of Patient A and failed to provide good clinical care in that she:

> *g. inappropriately recommended cholestyramine for Patient A which is not licensed for:*
>
> *i. children;*
>
> *ii. the reduction in OTA levels.*

114. The Tribunal was clear that Dr Monro did not prescribe Cholestyramine to Patient A. Patient A's mother was provided with an estimate which referred instead to Chlorella. A handwritten *"prescription"* on a pharmacy treatment sheet dated 1 October 2020 included Chlorella but not Cholestyramine. Furthermore, of the items printed on a patient

management care plan, *"Cholestyramine programme"* was crossed out. Instead, Chlorella was handwritten.

115. The paragraph of the Allegation refers, however, to Cholestyramine being recommended. The Tribunal had regard to the dictionary definition of 'recommended', which includes: *"advised or suggested as good or suitable"*, *"a suggestion that something is good or suitable for a particular purpose or job"*, and *"advice about what is the best thing to have or do"*.

116. The Tribunal took account of Dr Monro's clinical notes in Patient A's medical records recording her telephone consultation with Patient A's mother on 1 October 2020. This is set out by Dr E in her report. It records that:

> *"Mother*
> *Ochratoxin A 52.10. Aspergillus. Citrinine<2.5pg/ml*
> *Aspergillus [arrow pointing to ochratoxin]*
> *Cholestyramine* traps bile c mycotoxin 3/12*
> *Bile needed vit ADE, fats, diff time of day*
>
> *(Chlorella)"*

117. The Tribunal noted that the reference to Chlorella in the medical notes appears as something of an afterthought. There is no discussion about dosage, frequency, length of time over which it might be prescribed or its purpose. There is no explanation for why it appears separately and below the main entry or why it appears in brackets.

118. An estimate was sent to Patient A's mother by email on the same day (1 October 2020). The estimate listed the supplement of Chlorella, along with Vitamin A, B3 and E, as well as a number of oils but did not include Cholestyramine.

119. The Tribunal took account of the statement of Patient A's mother, which stated:

> *"22. I spoke to Dr Monro on the telephone on 1 October 2020, regarding [Patient A]'s test results. I remember her saying that the results had come back, and that they showed that a fungus was found, and that this was from water damage. I remember her saying that the normal level of mould was 7.5, but that [Patient A]'s was really elevated and needed to be treated as soon as possible.*
> *23. She also told us that in order to prevent further exposure that we had to keep [Patient A] our of water damaged or damp buildings, and that we would have to move if we were in a water damaged building.*

24. She said that the treatment was Colestyramine, and that this would draw the fungus and toxins out of [Patient A]'s system, which would prevent her from having liver and kidney failure, and that it would make her symptoms stop.
…
27. I have been asked by the GMC whether Dr Monro discussed chlorella medication at this appointment. She did not, she only discussed Colestyramine treatment.
28. Dr Monro said that she would prescribe the Colestyramine for [Patient A].
29. She did not mention Chlorella to us in that appointment."

120. Patient A's mother repeated this in evidence and confirmed that she was advised that Patient A would need to take additional vitamins and fats because the Cholestyramine would strip the body of essential nutrients which needed to be replaced.

121. The Tribunal was of the view that Patient A's mother believed that she was going to receive a prescription for Cholestyramine for her daughter based on what Dr Monro had told her. Patient A's mother received Dr Monro's letter dated 5 October 2020 accompanied by another copy of the estimate which only mentioned Chlorella. On 6 October 2020 she contacted Breakspear and asked where the prescription for the *"anti-fungal"* medication was.

122. Patient A's mother stated that she had not heard of Cholestyramine until it was mentioned to her by Dr Monro during the telephone consultation. Having regard to the mother's actions upon receipt of the 5 October 2020 letter and the medical records, the Tribunal concluded that Dr Monro must have told Patient A's mother about it during the 1 October 2020 telephone consultation. Moreover, it was apparent that Dr Monro believed that Cholestyramine was the correct treatment for removing mycotoxins as she referred to the *"Consensus statement"* upon which she based this belief in a letter to Patient A's GP dated 16 November 2020.

123. The Tribunal was unclear as to why Dr Monro would need to have discussed Cholestyramine with Patient A's mother in such detail if her recommendation was Chlorella. Moreover, the Tribunal could see no reason for the consultation record to be set out in the way described above, if Dr Monro's preferred treatment option was Chlorella. The whole of the consultation note refers to Cholestyramine and includes the length of time over which it was to be taken. The Tribunal noted that Patient A's mother had reported that during the 1 October consultation, Dr Monro advised that Cholestyramine required Patient A to take additional vitamins and fats. These are listed in the consultation note and appear in the estimate. There is no explanation in any medical record or letter as to why these would be required if Chlorella was the preferred treatment option. Chlorella is a herbal remedy which

would not have the adverse effects which the use of the Cholestyramine can cause and would not, therefore, have required the use of any supplements. Given the costs involved, the Tribunal does not accept that Dr Monro would have suggested such a wide range of unnecessary vitamins and fats had her recommendation been Chlorella.

124. The Tribunal concluded that the evidence of Patient A's mother about what occurred in the consultation was supported by the contemporaneous consultation note and that Dr Monro told her that Cholestyramine together with vitamins and fats was the appropriate treatment.

125. The Tribunal had regard to the letter dated 5 October 2020 from Dr Monro following the telephone consultation on 1 October 2020, which includes:

> *"Summary & Recommendations:*
>
> *I suggested that she could have colestyramine, which helps to trap bile and clear away the mycotoxins, but she would need vitamins A, D and E, as well as essential facts, if this were to be undertaken.*
>
> *However, because she is only five years old, it may be that taking a very small dose of Yaeyama Chlorella powder (1/4 teaspoon daily) might be helpful preferentially and this was suggested to [Patient A's mother].*
>
> *She was also recommended the following vitamins and oils…"*

126. The Tribunal considered that the wording used by Dr Monro in this section of the letter was unhelpful and was certainly not clear. In particular, if Dr Monro was seeking to convey that of the two options she discussed, she preferred Chlorella and that this was her recommendation, there was no explanation provided for why Patient A *"also recommended the following vitamins and oils…"*

127. The Tribunal also took account of emails between Patient A's mother and Breakspear on 7 October 2020, in which the mother said that no price list had been provided for the antifungal medication that Dr Monro had requested for Patient A. It was clarified by Breakspear that Chlorella was the antifungal treatment. Patient A's mother says: *"Dr Munro recommends clistorimine i think that how you spell it"*.

128. There was then somewhat of a break in the communication, during which time Patient A's mother took the 5 October 2020 letter from Dr Monro to Patient A's GP and Consultant Paediatrician.

129. In a letter dated 19/20 October 2020, Patient A's Consultant Paediatrician clearly understood that Dr Monro had recommended Cholestyramine. He stated:

> *"Thank you for your letter on this young lady and your inclusion of the recommendations of Dr Monro, who runs the Breakspear Medical Clinic, who recommends the treatment of the raised level of ochratoxin A with Cholestyramine.*
> *…*
> *There is no compelling evidence ochratoxin A is a meaningful pathogen in humans or that ochratoxin A in urinary measurements is any way related to diseases in humans. Also, Cholestyramine has no indication for the treatment of fungal disease and evidence for its efficacy in this area is also very poor, whilst evidence that it causes malnutrition in children is well established. I would therefore not be happy to prescribe these drugs myself."*

130. In email correspondence to Patient A's mother on 23 October 2020, staff at Breakspear sent a response on behalf of Dr Monro, which included:

> *"I was writing to you because the consultant paediatrician has alluded to my having recommended colestyramine for your daughter, but I did suggest chlorella, as you will see in the letter (copy attached for reference). The paediatrician is criticising the use of colestyramine.*
>
> *He said that there is no evidence of fungal disease as well. That is a separate issue from whether or not there are mycotoxins, and I have been sending your husband information on moulds and mycotoxins for the family to consider. This is attached again here for you."*

131. The Tribunal noted that Dr Monro did not specifically dispute that she had recommended Cholestyramine in the consultation on 1 October 2020.

132. In a letter to Patient A's GP on 16 November 2020, Dr Monro stated:

> *"In my communication I have said that it is possible to accumulate mycotoxins and they can re-circulate… I had provided a link to the findings of a report, written by Ritchie Shoemaker MD et all, which was published in Internal Medicine Review, Diagnostic Process for Chronic Inflammatory Response Syndrome (CIRS): A Consensus Statement Report of the Consensus Committee of Surviving Mold.*
> *…*
> *The suggestion that I had made about using colestryramine to clear the mycotoxins is what is recommended in the Consensus Statement but for [Patient A] I had recommended chlorella, a very mild supplement that is highly unlikely to have any side effects for a child."*

133. The Tribunal accepted Mr Hamlet's submissions that after becoming aware that her treatment plan had been shared with NHS doctors and in light of the criticisms by Patient A's Consultant Paediatrician, Dr Monro was seeking to distance herself from what had occurred in the 1 October 2020 consultation.

134. Dr Monro wrote to Patient A's mother on 18 November 2020 to notify her that she was discharging Patient A from the services at Breakspear. She stated that she had recently been in touch with Patient A's GP and that she had been informed there was a safeguarding action being undertaken. Dr Monro also stated:

> *"I note that you have not embarked on any treatment I recommended and that you did order the supplement chlorella for [Patient A] and I'm sure that this will be helpful."*
>
> The Tribunal noted that Dr Monro refers only to Chlorella, describes it as a *"supplement"* and makes no mention of the other vitamins and oils which appear on the estimate.

135. The Tribunal had regard to the expert report of Dr E, in which she stated:

> *"2.16.9. [59]: Letter to mother 23rd October 2020 sent "on behalf of Dr Monro".*
> *"I am writing to you because the Consultant Paediatrician… has alluded to my having recommended colestyramine for your daughter, but I did suggest chlorella, as you will see in the letter (copy attached for reference). The paediatrician is criticizing the use of colestyramine. He said that there is no evidence of fungal disease as well. This is a separate issue from whether or not there are mycotoxins, and I have been sending your husband information on moulds and mycotoxins for the family to consider. This is attached again here for you. I am so sorry if there has been a misunderstanding; I had thought that you have now gone to the paediatrician and therefore [Patient A's] care will be devolving to him, but if [Patient A] is to continue with attending me, then I would be happy to consider her progress after her chlorella."*
>
> *2.16.10. [58] email from [staff member at Breakspear] to Jean Monro, 27/07/2020.*
> *"[Patent A's] mother called this morning. She has been told the chlorella is not registered and would like this confirmed. She also asked if [Patient A] could be put on a very small dose of colestyramine. Lastly she wanted to know how we can help to get rid of the mould spores from her lungs and nasal passages, as since inhalation of the moulds, [Patient A] has had a blocked and runny nose and continuous sneezing. She has also had changes in her mental health? Asthma attacks and her sleep pattern has stopped. She has bruised eyes and her adenoids are inflamed. She said her throat? Is*

also red and itchy which she believes is caused by a bacterial infection/allergy to the moulds. She has had a bronchoscopy, but [Patient A's mother] is concerned that the mould spores will becomes embedded in [Patient A's] lungs and nose"

…

4.7. Dr Monro prescribed inappropriately for [Patient A].

4.7.1. The notes indicate that Dr Monro initially recommended cholestyramine and discussed this with the family. The note from the consultation of 01/10/2020 indicates a course length of 3 months was planned. However, there is no evidence that a prescription for cholestyramine was supplied.

…

5.2.7. Recommendation to the family of a medication (cholestyramine) which is neither licensed for children, nor licensed in adults for the proposed indication (reduction of OTA levels).

5.2.7.1. This fell seriously below as although not actually prescribed, discussion of its efficacy may have led the family to seek prescription from other practitioners or obtain from other sources in the belief it was the most effective agent for their child's condition."

and in the supplementary expert report:

"Typographical errors in my original report:
2.16.10 : date of email from *[staff member at Breakspear]* to Jean Monro was 27th October 2020"

136. In oral evidence, Mr Hamlet asked Dr E to clarify what her source was for the two assertions that Cholestyramine was not licensed for children and that it was not licensed in adults for the proposed indication. Dr E stated that the source was the British National Formulary (BNF).

137. The Tribunal accepted the evidence of Patient A's mother, that during the telephone consultation on 1 October 2020 Dr Monro recommended that Patient A take Cholestyramine, that she was advised to take this for 3 months together with a range of vitamins and fats and that those were necessary to counteract the effects of the Cholestyramine. This is consistent with what the Tribunal consider to be the first record of the consultation, the handwritten notes. It is also consistent with Dr Monro's understanding of the appropriate drug to be used to remove mycotoxins, which was Cholestyramine. The Tribunal concluded that while Patient A's mother believed that her child's symptoms were caused by ingesting mycotoxins produced from mould, she was unaware that Cholestyramine was a treatment until Dr Monro told her this. No reason has been provided for Patient A's mother to choose a more expensive treatment over a cheaper one, had that option been provided, nor to choose a medication with adverse side effects over a medication for her child which, as far as she was

aware, had none. The Tribunal therefore concluded that in the consultation Dr Monro did recommend the prescription of Cholestyramine and various supplements. The Tribunal further concluded that Patient A's mother understood that this was a recommendation and, unsurprisingly then pursued this when it did not appear on the estimate.

138. The Tribunal note the absence of any record of discussion with Patient A's mother about potential side effects of Chlorella which is consistent with her evidence. This also supports the Tribunal's conclusion that Chlorella was not discussed on 1 October and that, therefore, the treatment recommended was Cholestyramine.

139. Although the Tribunal has carefully considered the estimate sent out on the late afternoon of 1 October and the letter dated 5 October 2020 indicating that by the time these were written Dr Monro preferred Chlorella as a *"treatment"*, the reason given in the letter being Patient A's age, this does not change the Tribunal's conclusions given its acceptance of the mother's evidence, the contemporaneous note of the consultation and the otherwise unexplained recommendation concerning vitamins and fats. While Dr Monro appears to have changed her position by the time she completed the form which formed the basis of the estimate and in her letter dictated on 1 October 2020 but not sent until 5 October 2020, the Tribunal has no evidence as to any reason for this and will not speculate about that.

140. The Tribunal therefore determined that, on the balance of probabilities, it was more likely than not that Dr Monro failed to provide good clinical care in that she inappropriately recommended Cholestyramine for Patient A, which is not licensed for children or the reduction in OTA levels.

Paragraph 2(a) and (b)

141. The Tribunal considered whether, on 29 July 2020, Dr Monro inappropriately prescribed to Patient A: (a) Nutrisorb Liquid Zinc Plus Ascorbate 30 millilitre ('ml') ten drops daily, and/or (b) Bio D 15ml, four drops once daily - for protection against Covid, when she had no evidence of its efficacy against Covid.

142. The Tribunal had regard to the clinic letter from Dr Monro dated 3 August 2020, following the initial telephone consultation with Patient A's mother on 29 July 2020. At the end of this letter, Dr Monro stated:

> *"In the meantime, I have recommended that she takes the following supplements as protection against Covid-19:*

- *Nutrisorb Liquid Zinc Plus Ascorbate 30ml, 10 drops daily (in water)*
- *Bio-D (Liquid Vitamin D) 15ml, 4 drops once daily"*

143. The Tribunal had regard to the expert report of Dr E, in which she stated:

> *"4.7.2. On the first visit Dr Monro prescribed medication on 29/07/2020 alleging protection against COVID. These were Nutrisorb Liquid Zinc Plus Ascorbate 30ml 10 drops daily (in water) and Bio D (liquid vitamin D) 15ml, 4 drops once daily". Dr Monro had no evidence that [Patient A] was deficient in zinc, or vitamins C or D and there is no evidence that either has activity against COVID.*
> *…*
> *5.2.6. Prescription of agents with the claim that they had medicinal properties, for which there was no evidence of efficacy based on the best available evidence, as outlined in 4.7.2 and 4.7.3 (GMP 16b)*
>
> *5.2.6.1. This fell seriously below standard of care as these agents were not approved as medicines, safety of some of these agents, and appropriate dosing had not been established in children, they had the potential to cause harm, in terms of side effects and risk of allergic reaction and obtaining them resulted in a financial burden for the family."*

144. The Tribunal relied upon the evidence of Dr E in this regard, which it found to be persuasive. The Tribunal determined that, on the balance of probabilities, it was more likely than not that Dr Monro inappropriately prescribed to Patient A: (a) Nutrisorb Liquid Zinc Plus Ascorbate 30 millilitre ('ml') ten drops daily, and/or (b) Bio D 15ml, four drops once daily - for protection against Covid, when she had no evidence of its efficacy against Covid. Accordingly, the Tribunal found paragraph 2(a) and (b) of the Allegation proved.

<u>Paragraph 3(a) to (c)</u>

145. The Tribunal considered whether, on 20 October 2020, Dr Monro prescribed Chlorella to Patient A claiming it had medicinal properties in removing mould toxins, which was inappropriate as:

a. there was no scientific basis for this claim;

b. it had the potential to cause harm in terms of the side effects and allergic reactions;

c. those with allergy to moulds can be allergic to Chlorella.

146. The Tribunal had regard to the prescription from Breakspear dated 20 October 2020 for the Chlorella and the vitamins for Patient A.

147. Within an email dated 27 October 2020, a staff member at Breakspear responded to Patient A's mother with a response from Dr Monro. Within in this email it stated:

> *"Chlorella is something which has been shown to be helpful for removing mould toxins and I understand that you have bought this for [Patient A]."*

148. The Tribunal had regard to the expert report of Dr E, in which she stated:

> *"4.7.3. Dr Monro subsequently prescribed Chlorella on 20/10/2020 claiming medicinal properties in terms of demonstrated benefit in removing mould toxins. There is no scientific basis for the claims made by Dr Monro. Chlorella is sold as a dietary supplement derived from algae. Companies in the USA advertising this product for treatment of medical symptoms have been sanctioned by the FDA. While generally well tolerated, its safety has not been demonstrated in children, and side effects include abdominal pain, nausea, flatulence, loose and/or green stools. Allergic reactions, including anaphylaxis are described, as is photosensitivity. While not substantiated by her paediatricians, mother's initial belief was that [Patient A]'s symptoms were due to an allergy to the mould to which she was exposed. Those with allergy to moulds can be allergic to Chlorella. There is no evidence that this was discussed with the family before prescribing."*

149. The Tribunal noted the evidence of Patient A's mother that she was clear that these matters at 3(b) and (c) had never been discussed with her. There is no reference in Patient A's medical records to indicate that Dr Monro had discussed side effects or allergies regarding Chlorella with Patient A's mother.

150. The Tribunal relied upon the evidence of Dr E, which it found to be determinative. The Tribunal determined that, on the balance of probabilities, it was more likely than not that Dr Monro acted in the manner set out in paragraphs 3(a) to (c) of the Allegation such that the prescription was inappropriate. Accordingly, the Tribunal found paragraphs 3(a) to (c) of the Allegation proved.

<u>Paragraph 3(d)</u>

151. The Tribunal considered whether, on 20 October 2020, Dr Monro prescribed Chlorella to Patient A claiming it had medicinal properties in removing mould toxins, which was inappropriate as:

…

d. she failed to discuss the matters described in paragraphs 3.b. and 3.c. with Patient A's parents before prescribing.

152. The Tribunal had regard to the statement of Patient A's mother, which stated:

"I have been asked by the GMC whether Dr Monro discussed chlorella medication at this appointment. She did not, she only discussed Colestyramine treatment.

Dr Monro said that she would prescribe the Colestyramine for [Patient A].

She did not mention Chlorella to us in that appointment."

153. As referenced above, the Tribunal noted the evidence of Patient A's mother that she was clear that these matters at 3(b) and (c) had never been discussed with her. There did not appear to be any reference in Patient A's medical records to indicate that Dr Monro had discussed side effects or allergies with Patient A's mother. She reiterated these comments in her oral evidence to the Tribunal. The Tribunal found this to be consistent with the witness statement and found her evidence to be persuasive on this point. The Tribunal was unable to find any documentation to suggest that side effects or allergies were discussed with Patient A.

154. The Tribunal had regard to the expert report of Dr E, along with the 4.7.3 section quote above, in which she also stated:

"5.2.6. Prescription of agents with the claim that they had medicinal properties, for which there was no evidence of efficacy based on the best available evidence, as outlined in 4.7.2 and 4.7.3 (GMP 16b)

5.2.6.1. This fell seriously below standard of care as these agents were not approved as medicines, safety of some of these agents, and appropriate dosing had not been established in children, they had the potential to cause harm, in terms of side effects and risk of allergic reaction and obtaining them resulted in a financial burden for the family."

155. The Tribunal relied upon the evidence of Dr E and determined that, on the balance of probabilities, it was more likely than not that Dr Monro had failed to discuss the matters described at paragraphs (b) and (c) before prescribing such that the prescription was inappropriate. Accordingly, the Tribunal found paragraph 3(d) of the Allegation proved.

<u>Paragraph 3(e)</u>

156. The Tribunal considered whether, on 20 October 2020, Dr Monro prescribed Chlorella to Patient A claiming it had medicinal properties in removing mould toxins, which was inappropriate as:

> …
> *e. she knew obtaining this prescription would result in a heavy financial burden to Patient A's parents.*

157. The Tribunal had regard to the expert report of Dr E, in which she stated:

> *"5.2.6. Prescription of agents with the claim that they had medicinal properties, for which there was no evidence of efficacy based on the best available evidence, as outlined in 4.7.2 and 4.7.3 (GMP 16b)*
> *5.2.6.1. This fell seriously below standard of care as these agents were not approved as medicines, safety of some of these agents, and appropriate dosing had not been established in children, they had the potential to cause harm, in terms of side effects and risk of allergic reaction and obtaining them resulted in a financial burden for the family."*

158. The Tribunal had regard to the Breakspear price estimate documentation in respect of the Chlorella. This listed the cost of a 12-week supply of Chlorella as £11.60. The Tribunal appreciated that the matter of a 'heavy financial burden' was a qualitative assessment but noted the actual cost of Chlorella, which was quite low. The Tribunal appreciated that it had not heard details of the specific financial situation that Patient A's parents were in, apart from that they had borrowed some money from family to allow them to travel and stay in a hotel for the appointment.

159. The Tribunal had difficulty given the relative low cost of Chlorella to find that this amounted to a 'heavy financial burden' as set out in this paragraph of the Allegation. It was not satisfied, on the balance of probabilities, that Dr Monro knew this prescription would result in a heavy financial burden to Patient A's parents. It concluded, based on the evidence before it, that the GMC had not discharged the burden of proof upon it. Accordingly, the Tribunal found paragraph 3(e) of the Allegation not proved.

Paragraph 4

160. The Tribunal considered whether, on or after 30 April 2020, Dr Monro failed to obtain adequate consent in her assessment and treatment of Patient A in that she did not explain

the implications of agreeing to the administration of unregulated investigations and unlicensed medication.

161. The Tribunal noted Mr Hamlet's submissions on behalf of the GMC that 'adequate' consent meant 'informed' consent.

162. The Tribunal had regard to the expert report of Dr E, in which she stated:

> *"2.10. There is no contemporaneous record of the telephone discussion subsequently had with Dr Monro.*
> *2.11. [28] Consent to go ahead with mycotox and organic tests was signed by [Patient A's mother] on 10/09/2020.*
> *…*
> *4.8.1. A consent to treatment form was signed as part of the initial assessment document. dated 30/04/2020. This was completed before any documented contact with Dr Monro, or any other professional qualified to take consent. The entry of "N/A" beside the name of the healthcare professional taking consent would strongly suggest that no discussion by a medical professional had already taken place…*
> *…*
> *4.8.3. In many circumstances, consent is implied if after adequate explanation of the reason for treatment, and its potential benefits and side effects, the treatment is taken by the patient (or given to the child). There is no documented evidence that such a discussion took place.*
> *…*
> *5.2.8. Failure to gain adequate consent before engaging on assessment and treatment.*
>
> > *5.2.8.1. This fell seriously below standard as the consent form signed on 30/04/2020 included agreeing to the administration of unlicensed medication to a child, and there is no evidence of any discussion or explanation of the implications of this taking place before requiring a signature. Furthermore there is no evidence of adequate consent being obtained after full explanation for the subsequent investigation and treatment, especially in the light of unregulated investigations and unlicensed treatment."*

163. The Tribunal had regard to the GMC guidance on 'Decision making and consent' which has been in effect from 9 November 2020. It also noted the previous version entitled 'Consent: patients and doctors making decisions together' that had been in place since 2008. Within the November 2020 guidance, it stated:

> *"The seven principles of decision making and consent*
>
> > *…*
> > *Two - Decision making is an ongoing process focused on meaningful dialogue: the exchange of relevant information specific to the individual patient.*

…
10. You must give patients the information they want or need to make a decision. This will usually include:
a. diagnosis and prognosis
b. uncertainties about the diagnosis or prognosis, including options for further investigation
c. options for treating or managing the condition, including the option to take no action
d. the nature of each option, what would be involved, and the desired outcome
e. the potential benefits, risks of harm, uncertainties about and likelihood of success for each option, including the option to take no action.
By 'harm' we mean any potential negative outcome, including a side effect or complication."

21. You must give patients clear, accurate and up-to-date information, based on the best available evidence, about the potential benefits and risks of harm of each option, including the option to take no action.

22. It wouldn't be reasonable to share every possible risk of harm, potential complication or side effect. Instead, you should tailor the discussion to each individual patient, guided by what matters to them, and share information in a way they can understand."

164. The Tribunal was clear that the GMC guidance on consent sets out a doctor's responsibilities. A patient, or their parent, should be provided with all the information that they want or need to make a decision, and this should include that they are aware of risks/benefits and likely outcomes.

165. Patient A's mother had agreed to the mycotoxin test for her daughter. She was informed through the paperwork she was sent that this was a test undertaken in an American laboratory and that it was not approved by the FDA. However, Patient A's mother was not told, in specific terms, that the Test was not diagnostic in nature. She also agreed to the Chlorella but did not appear to have known that this was unlicensed. The Tribunal referred to its previous findings in respect of these two matters.

166. Patient A's mother had completed a standard consent form on behalf of her daughter on 30 April 2020, which was part of the material provided by Breakspear when she originally contacted them. This was signed and completed before Patient A's mother ever had the first telephone consultation with Dr Monro. The Tribunal appreciated Dr E's opinion that the completion of this form was not the same as informed consent. The Tribunal was clear that the signing of this document did not amount to blanket consent of everything that then followed; a signature was not evidence of informed consent.

167. The Tribunal had made a series of determinations about what had been said to Patient A's mother by Dr Monro and concluded that there were important pieces of information that were not relayed to Patient A's mother. She was not given a full explanation of the risks and benefits of the Test or Chlorella, and therefore she was not in a position on behalf of her child to make an informed decision and give consent to whatever she decided. Of particular concern was the failure to tell her about any potential side effects. Overall, the Tribunal determined that the guidance regarding consent had not been complied with in this instance.

168. The Tribunal determined that, on the balance of probabilities, it was more likely than not that Dr Monro failed to obtain adequate consent in her assessment and treatment of Patient A in that she did not explain the implications of agreeing to the administration of unregulated investigations and unlicensed medication. Accordingly, the Tribunal found paragraph 4 of the Allegation proved.

The Tribunal's Overall Determination on the Facts

169. The Tribunal has determined the facts as follows:

That being registered under the Medical Act 1983 (as amended):

1. Between 30 April 2020 and 18 November 2020 you were involved in the care and treatment of Patient A. You failed to provide good clinical care in that you:

a. did not take an environmental history to establish whether there were any ongoing risks of exposure to fungal or other toxins in Patient A's environment, including from:
Amended under Rule 17(6)

i. ongoing exposure to moulds;
Determined and found proved

ii. consumption of foods potentially high in Ochratoxin A ('OTA');
Determined and found proved

b. did not ensure an examination of Patient A's:

i. pulse rate and blood pressure;
Determined and found proved

ii. abdomen;
Determined and found proved

was carried out;

c. did not make an appropriate differential diagnosis based on the presenting symptoms;
Not proved

d. arranged investigation by Mycotoxin urine test ('the Test') which was inappropriate to explore the possibility of illness due to fungal infection;
Determined and found proved

e. did not record the relevance of the Test results to Patient A's condition and treatment;
Determined and found proved

f. provided information to Patient A's parents based on the Test's laboratory report ('the Report'):

i. which asserted that the Test was done in a ~~CILA~~ CLIA approved laboratory before verifying that it was accredited;
Amended under Rule 17(6)
Not proved

ii. by providing an incomplete transcript of the Report without clinical context;
Determined and found proved

iii. without alerting them to:

1. the limitations of the Test;
Determined and found proved

2. the fact that it was performed in a laboratory that did not conform to NHS standards;
Amended under Rule 17(6)
Not proved

3. the fact that it was not approved in the United States;
Amended under Rule 17(6)
Not proved

4. which (if any) of the toxic effects outlined in the Report had been experienced by Patient A;

Determined and found proved

5. whether any further investigations were necessary to explore the possibility of such toxic effects;
Not proved

6. how further exposure could be prevented;
Determined and found proved

iv. which, in the alternative to paragraph 1.f.iii, having alerted them to the features set out in paragraph 1.f.iii and believing that Patient A did not have toxicity, you failed to:

1. reassure Patient A's parents;
Not considered

2. explain the reason for needing treatment;
Not considered

g. inappropriately recommended cholestyramine for Patient A which is not licensed for:

i. children;
Determined and found proved

ii. the reduction in OTA levels;
Determined and found proved

2. On 29 July 2020 you inappropriately prescribed to Patient A:

a. Nutrisorb Liquid Zinc Plus Ascorbate 30 millilitre ('ml') ten drops daily;
Determined and found proved

b. Bio D 15ml, four drops once daily;
Determined and found proved

for protection against COVID, when you had no evidence of its efficacy against Covid.

3. On 20 October 2020 you prescribed Chlorella to Patient A claiming it had medicinal properties in removing mould toxins, which was inappropriate as:

a. there was no scientific basis for this claim;
Determined and found proved

b. it had the potential to cause harm in terms of the side effects and allergic reactions;
Determined and found proved

c. those with allergy to moulds can be allergic to Chlorella;
Determined and found proved

d. you failed to discuss the matters described in paragraphs 3.b. and 3.c. with Patient A's parents before prescribing;
Determined and found proved

e. you knew obtaining this prescription would result in a heavy financial burden to Patient A's parents.
Not proved

4. On or after 30 April 2020 you failed to obtain adequate consent in your assessment and treatment of Patient A in that you did not explain the implications of agreeing to the administration of unregulated investigations and unlicensed medication.
Determined and found proved

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

Determination on Impairment - 14/08/2024

170. The Tribunal now has to decide in accordance with Rule 17(2)(l) of the Rules whether, on the basis of the facts which it has found proved as set out in its previous determination, Dr Monro's fitness to practise is impaired by reason of misconduct.

171. At the outset of the impairment stage, Mr Hamlet informed the Tribunal that Dr Monro was currently subject to an existing order of suspension in relation to a separate case. That case, relating to Patient B, was considered by a Medical Practitioners Tribunal (MPT) from 11 to 28 April 2023 ('the 2023 Tribunal'). Mr Hamlet invited the Tribunal to also conduct a review of that matter under Rule 22(1)(f) of the Rules.

The 2023 Tribunal Background

172. The 2023 Tribunal hearing related to Patient B, a five-year-old boy, who had been given a diagnosis. This diagnosis was not made by Dr Monro.

173. The 2023 Tribunal found proved that, from March 2015 onwards, Dr Monro's care and treatment of Patient B was inadequate. Specifically, the Tribunal concluded that she referred Patient B for neurophysiological investigation using a Neuroscope, an experimental diagnostic tool, which was not clinically indicated for Patient B's presenting symptoms. The 2023 Tribunal concluded that Dr Monro's approach was unconventional and inconsistent with standard paediatric medical diagnoses and management protocols, was outside of a clinical trial, and could not provide an identifiable treatment outcome.

174. The 2023 Tribunal also found proved that, from March 2015 onwards, Dr Monro's care and treatment of Patient B was inadequate in that she supported therapeutic intervention which involved Patient B having to wear an oxygen facemask for several hours a day. Moreover, the treatment was experimental in nature and of unproven benefit. This resulted in Patient B using oxygen for four hours daily via face mask which the GMC expert told the 2023 Tribunal could cause Patient B physical and/or psychological harm.

175. The 2023 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.

176. The 2023 Tribunal noted that Dr Monro had said that she had retired from medical practice, was not going to resume medical practice and had relinquished her licence to practise. She had applied for voluntary erasure prior to the commencement of the 2023 Tribunal hearing, however, this was not granted.

177. The 2023 Tribunal was not provided with evidence of actual harm to Patient B. However, it considered that Dr Monro's behaviour had placed Patient B who was particularly vulnerable due to his age, at risk of harm. The 2023 Tribunal considered that given Dr Monro's age and that she stated she had retired, she was unlikely to return to medical practice and therefore any future risk of harm was low.

178. The 2023 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. The 2023 Tribunal determined that Dr Monro's fitness to practise was impaired by reason of misconduct and referred to the absence of any evidence of insight or remediation.

179. The 2023 Tribunal noted that Dr Monro had not provided any evidence of regret, apology, remediation, or insight into risks posed by her misconduct. There was no reflective statement or other indication that Dr Monro had thought about the impact on Patient B of

the referral for investigation with a Neuroscope and treatment requiring him to wear an oxygen mask for several hours a day.

180. The 2023 Tribunal determined to suspend Dr Monro's registration for 12 months, directed a review hearing, and imposed an immediate order. The 2023 Tribunal determined that this would provide sufficient time for Dr Monro to reflect on her misconduct and develop insight. The 2023 Tribunal stated that it would assist the reviewing Tribunal to be provided with a reflective statement from Dr Monro.

The Outcome of Applications made during the Impairment Stage

181. On 3 June 2024 the Tribunal determined that service of the notice of the review aspect of this hearing had been effected. The Tribunal also determined to proceed with the hearing in Dr Monro's absence. The Tribunal's full decision on this matter is included at Annex C.

182. Due to insufficient time to conclude the hearing, the Tribunal determined to adjourn part heard on 5 June 2024 and extended the suspension on Dr Monro's registration for a period of three months. The Tribunal's full decision on this matter is included at Annex D.

The Evidence

183. There is no requirement for service of the resumed date of hearing upon Dr Monro to be formally proved, however, the Tribunal noted that Dr Monro had been provided with three emails confirming this.

184. The Tribunal has taken into account all the evidence received during the facts stage of the 2024 Tribunal hearing, both oral and documentary. The Tribunal was also provided with additional documentation relating to Dr Monro's review. This evidence included, but was not limited to, the following:

- The determination of the 2023 Tribunal;
- A note of a telephone conversation between Dr Monro and the GMC on 29 July 2023;
- Correspondence from the GMC to Dr Monro dated 27 July 2023 and 31 January 2024 which provided an opportunity for her to submit any evidence that she wanted the Tribunal to consider when reviewing the suspension.

Submissions

185. On behalf of the GMC, Mr Hamlet submitted that the Tribunal should approach the issue of impairment in two-stages. It should first determine whether the facts found proved in this hearing amount to misconduct and that misconduct is serious. Then, if the Tribunal concluded that the facts found proved did amount to serious misconduct, it should assess globally, taking into account the findings of both Tribunals, whether Dr Monro's fitness to practise is currently impaired.

186. Mr Hamlet dealt first with whether the findings made by this Tribunal amounted to misconduct, and whether that misconduct was serious.

187. Mr Hamlet referred to the case of *Roylance v GMC* (No 2) [2000] 1 AC 311, in which it was said that:

> "*Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a medical practitioner in the particular circumstances*."

188. Mr Hamlet then reminded the Tribunal that 'misconduct' has no statutory definition. It is a matter for the judgement and experience of the Tribunal. He further reminded the Tribunal of the guidance given in *Remedy UK Ltd v GMC* [2010] EWHC 1245 in which Elias LJ derived the following principles from the authorities:

> *'Misconduct is of two principal kinds: (1) Firstly it may involve sufficiently serious misconduct in the exercise of professional practice such as it can properly be described as misconduct going to fitness to practice; (2) second it can involve conduct of a morally culpable or otherwise disgraceful kind which may and often will occur outside the course of professional conduct itself but which brings disgrace upon the doctor and thereby prejudices the reputation of the profession.'*

189. Finally, Mr Hamlet referred the Tribunal to the case of *Nandi v GMC* [2004] EWHC 2317 (Admin), in which it was said that serious misconduct is sometimes described as misconduct which would be considered deplorable by fellow practitioners.

190. Mr Hamlet submitted the findings made are plainly serious. They are wide ranging failures commencing with Dr Monro's initial history taking and examination of Patient A. Mr Hamlet also submitted that Dr Monro arranged an inherently flawed and inappropriate investigation; and provided inappropriate advice and treatment which was not rooted in

scientific or clinical fact and which did not serve the best interests of Patient A. He submitted Dr Monro's conduct falls squarely into the category of misconduct.

191. Mr Hamlet submitted that, taking the Review case into consideration, the Tribunal can safely conclude that Dr Monro's fitness to practise in relation to that matter and the present case is currently impaired. He submitted that it has been highlighted that Dr Monro has produced no evidence of regret or insight and there has been no reflection, no acknowledgement of fault, and no attempt at any remediation by her.

192. Mr Hamlet finally submitted that in regard to the public interest, two elements are relevant – maintaining public confidence in the profession and upholding proper standards for the profession. Mr Hamlet submitted that an impartial observer would be disturbed by Dr Monro's conduct as would a fellow professional. Mr Hamlet finally submitted that Dr Monro's fitness to practise is currently impaired.

193. Dr Monro was not present or represented. There were no written submissions from Dr Monro regarding impairment.

The Relevant Legal Principles

194. The Tribunal reminded itself that at this stage of proceedings, there is no burden or standard of proof and the decision of impairment is a matter for the Tribunal's judgement alone.

195. In approaching the decision, the Tribunal was mindful of the two-stage process to be adopted: first whether the facts as found proved amounted to misconduct, and that the misconduct was serious, and then whether the finding of that misconduct which was serious, could lead to a finding of impairment. The Tribunal was also mindful of the review aspect of the case, as to whether Dr Monro's fitness to practise continued to be impaired by reason of the misconduct that resulted in the suspension being placed upon her registration.

196. The Tribunal must determine whether Dr Monro's fitness to practise is impaired today, taking into account Dr Monro's 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.

197. The Tribunal was reminded that whilst there is no statutory definition of impairment. The Tribunal was referred to the guidance provided by Dame Janet Smith in the Fifth Shipman report as adopted by the *High Court in CHRE v NMC and Paula Grant* [2011] EWHC

927 (Admin) ('*Grant*'). In particular the Tribunal should consider whether its finding of facts showed that Dr Monro's fitness to practise is impaired in the sense that she:

> *'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 or is likely 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.'*

198. The Tribunal were advised that the purpose of fitness to practise hearings is not to punish the practitioner for past misdoings but to protect the public against the acts and omissions of those who are not fit to practise. Consequently, the test of current impairment is a forward looking one. This 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.

199. The Tribunal is concerned with Dr Monro's fitness to practice today and going forwards.

200. The Tribunal were advised that any view about current fitness to practice must be gauged partly by the practitioner's past conduct or performance. The Tribunal were referred to *Meadow v GMC* [2006] EWCA Civ 1390) and partly by reference to how he is likely to behave or perform in the future. (*Zygmunt v GMC* [2008] EWHC 2643 (Admin)) 11).

201. The LQC also drew the Tribunal's attention to *Cohen v GMC* (2008) EWHC 581 in which the Court held that the task of the panel, in considering impairment, is to take account of the practitioner's misconduct and then consider it in light of all the other relevant factors known to them. The Court stated that it will be highly relevant in determining if fitness to practise is impaired to consider:

- whether the practitioner's misconduct is easily remediable;
- whether the misconduct has been remedied; and
- whether the misconduct is likely to be repeated

The Tribunal's Determination on Impairment

<u>Misconduct (New Allegation)</u>

202. The Tribunal first considered whether Dr Monro's actions amount to misconduct, and whether that misconduct was serious, given the facts found proved in this hearing.

203. The Tribunal found that Dr Monro's conduct overall was a clear departure from paragraphs 14, 15(a), 15(b), 16(a), 16 (b), 17 and 32 of Good Medical Practice (2013, as amended) ('GMP 2013').

'14 You must recognise and work within the limits of your competence.

15 You must provide a good standard of practice and care. If you assess, diagnose or treat patients, you must:

a adequately assess the patient's conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views and values; where necessary, examine the patient

b promptly provide or arrange suitable advice, investigations or treatment where necessary.

16 In providing clinical care you must:

a prescribe drugs or treatment, including repeat prescriptions, only when you have adequate knowledge of the patient's health and are satisfied that the drugs or treatment serve the patient's needs.

b provide effective treatments based on the best available evidence

17 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.

32 You must give patients the information they want or need to know in a way they can understand. You should make sure that arrangements are made, wherever possible, to meet patients' language and communication needs.'

204. The Tribunal determined that the various failures of Dr Monro departed from a number of the fundamental tenets of good professional practice, namely, diagnosis, investigation, prescribing, consent and communication.

205. The Tribunal therefore concluded there was sufficient evidence of misconduct. The Tribunal considered that many of the breaches were interlinked and overlapping, relating to diagnosis, appropriateness of investigations, prescription, consent and communication.

206. Although the Tribunal accepted that there was no evidence that Patient A had been harmed as a result of Dr Monro's misconduct, nonetheless, a young child had been put at potential risk of harm. The Tribunal further considered that there was no evidence that the treatment provided to Patient A by Dr Monro would have afforded her any benefit and could have put her at risk of harm.

207. The Tribunal further concluded that the public expect doctors to take an appropriate medical history, conduct the tests necessary to make a diagnosis, understand whether a test is diagnostic or not and whether using it would assist in making a diagnosis. The public also expect a doctor to able to interpret and explain the results of tests to patients, or in the case of children, their parents. The public also expect a doctor to recommend appropriate medication and/or treatment and not to propose medication/treatment in respect of which there is no scientific evidence of efficacy.

208. The Tribunal therefore determined that Dr Monro's conduct fell so far short of the standards reasonably to be expected of a doctor as to amount to serious misconduct.

Impairment by reason of misconduct (New Allegation and Review)

209. The Tribunal, having found that the facts found proved amounted to misconduct, and that misconduct was serious, went on to consider whether Dr Monro's fitness to practise is currently impaired by reason of her misconduct. In considering current impairment, the Tribunal also took into account the misconduct that resulted in the suspension being placed upon her registration by the 2023 Tribunal.

210. The Tribunal considered the following questions when determining the issue of impairment:

i. Is Dr Monro's misconduct easily capable of remediation?
ii. Has Dr Monro remediated her misconduct;
iii. Is the misconduct highly unlikely to be repeated?
iv. Is a finding of impairment necessary to protect the public?
v. Is a finding of impairment necessary to declare and uphold proper standards of behaviour so as to maintain public confidence in the profession?

211. The Tribunal noted that the misconduct found proved is capable of remediation. The Tribunal has, however, received no evidence that Dr Monro has taken any steps to remediate. The Tribunal further noted that Dr Monro described in a phone call on 27 July 2023 that *"she felt unfairly treated - that she had been punished when she had not prescribed for the child and the doctor who did prescribe was treated less severely"*. The Tribunal considered that this showed that Dr Monro had not recognised the nature or gravity of her own misconduct. Moreover, Dr Monro had not provided any reflection to this Tribunal about the outcome of the 2023 Tribunal, as suggested, or about the outcome of stage 1 of this Tribunal. The Tribunal could find no evidence of Dr Monro developing her understanding of the misconduct or addressing the findings of the 2023 Tribunal.

212. The Tribunal reminded itself of the contents of an email sent by Mr D, XXX and Registered Manager/Managing Director at Breakspear Medical Group Ltd, dated 10 October 2023. He stated:

> *"Jean Monro has retired from the practise of medicine; she surrendered her licence to practise more than 2 years ago, she has also twice applied for 'voluntary erasure' and her membership with the General Medical Council lapsed at the end of 2021.*
>
> *Jean Monro does not propose to engage any further with the GMC or the MPTS."*

213. The Tribunal reminded itself that its judgment should be informed by reference to whether, if permitted to practise, Dr Monro would be fit to do so without restriction. The test of current impairment is not whether Dr Monro intends to practise or not. While repetition of her misconduct may be improbable given Dr Monro's retirement, the fact of her retirement did not assist the Tribunal with the issue of her actual fitness to practise. The Tribunal also noted that by virtue of her retirement and as a result of not having practised since August 2023, Dr Monro's skills are likely to have declined further.

214. The Tribunal therefore concluded that while the misconduct was capable of remediation, in the absence of any evidence that Dr Monro had remediated her misconduct, Dr Monro's fitness to practise is impaired. The Tribunal also concluded that given the reduction of her skill set as a result of being out of practice coupled with an absence of insight into her misconduct, which involved two very young and vulnerable patients, if Dr Monro were to practise without restriction there would be a risk of harm to the public.

215. Finally the Tribunal reminded itself of the need to maintain public confidence in the profession by declaring and upholding professional standards. The current proceedings and the 2023 proceedings related to young, vulnerable patients. Both concerned an unconventional approach to diagnosis and treatment. In both cases, while no harm was

occasioned to either patient, there was a risk of harm. The decision making in both cases reveals a concerning pattern of conduct concluding with each patient receiving treatment which was of no benefit to them and which could potentially have caused them harm. Dr Monro has not engaged with the proceedings in either Tribunal. She has shown no regret, remorse or insight and engaged in no remediation. The Tribunal concluded that public confidence in medical professionals and their regulatory system would be significantly undermined if it did not make a finding that Dr Monro's fitness to practise is impaired.

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

Determination on Sanction - 16/08/2024

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

The Evidence

218. The Tribunal has taken into account all of the evidence received during the earlier stages of the hearing where relevant to reaching a decision on sanction.

Submissions

219. On behalf of the GMC, Mr Hamlet submitted that the appropriate sanction is one of erasure. Mr Hamlet referred to a number of paragraphs in the Sanctions Guidance (February 2024) (the 'SG'), Good Medical Practice (GMP) and the Tribunal's determination on impairment.

220. Mr Hamlet first invited the Tribunal to consider the aggravating and mitigating factors. He submitted that the continued absence of insight is an aggravating factor; also of particular concern is Dr Monro's lack of engagement. Mr Hamlet further highlighted the absence of any remediation on Dr Monro's part, which is relevant to the risk of repetition. Mr Hamlet reminded the Tribunal that in its Stage 2 determination, it had concluded that Dr Monro's misconduct impairs her fitness to practise on all three grounds of the overarching objective.

221. Mr Hamlet submitted that Dr Monro's misconduct did not consist of isolated incidents but concerned two patients over a period of time. He referred the Tribunal to what he

described as a pattern of misconduct across the two cases. Mr Hamlet stated that Dr Munro has produced no evidence to the Tribunal indicating regret, remorse or remediation. Mr Hamlet submitted that as a result, if Dr Monro were to return to practice there is a high likelihood of repetition because she has no insight into her failings.

222. Mr Hamlet submitted that there were no exceptional circumstances in this case which would allow the Tribunal to take no action.

223. Mr Hamlet further submitted that conditions would not be appropriate in this case as Dr Munro had failed to engage with the 2023 Tribunal proceedings or with these proceedings. He therefore submitted that Dr Monro would be unlikely to respond positively to, or abide by, conditions.

224. Mr Hamlet turned to suspension. He submitted that suspension may be appropriate where the Tribunal considered temporary removal of a doctor from practice was necessary to allow the doctor to reflect on where they have gone wrong. Mr Hamlet further submitted, however, that if there is no prospect of reflection, which is a necessary precondition to change, suspension would not be an appropriate sanction. Mr Hamlet submitted there is therefore little practical value in temporarily suspending Dr Monro from the register where the evidence strongly suggests that she would not be fit to return to unrestricted practice at the end of that term.

225. Mr Hamlet referred the Tribunal to paragraph 109 of the SG, which states:

> *'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 difficult to remediate.*
>
> *b A deliberate or reckless disregard for the principles set out in Good medical practice and/or patient safety.*
>
> *…*
>
> *e Violation of a patient's rights/exploiting vulnerable people.*
>
> *…*
>
> *j Persistent lack of insight into the seriousness of their actions or the consequences. '*

226. Mr Hamlet submitted these four subparagraphs applied to this case.

227. Finally, Mr Hamlet submitted that as this Tribunal had concluded that her fitness to practise is currently impaired, in the absence of any insight, acknowledgement of her failings and/or remediation, the proper outcome should be erasure.

228. There were no written submissions provided by Dr Monro regarding sanction. The Tribunal had regard to the various correspondence from Dr Monro that it has referred to at earlier stages.

The Tribunal's Determination on Sanction

229. The decision as to the appropriate sanction to impose, if any, in this case is a matter for this Tribunal exercising its own judgement.

230. In reaching its decision, the Tribunal has taken account of the SG and of the overarching objective. It has borne in mind that the purpose of the sanctions is not to be punitive, but to protect patients and the wider public interest, although they may have a punitive effect.

Aggravating and mitigating factors

231. The Tribunal first considered whether any mitigating features were present.

232. The Tribunal first considered Dr Monro's length of service as a doctor. Although Dr Monro was first registered as a doctor in 1960, the Tribunal has no information about her career and she has provided no references or testimonials. The Tribunal was told that Dr Monro received a warning in 2012 and is aware that she was suspended from practising in 2023 as a result of misconduct that occurred in 2015. In light of the lack of information available, the Tribunal was unable to conclude that Dr Monro's long service as a doctor was a mitigating feature.

233. The Tribunal then considered whether Dr Monro's retirement from practising as a doctor at least 2 years ago, her request for voluntary erasure, her decision not to renew her medical licence and her stated intention not to return to practice as a doctor amounted to mitigation.

234. The Tribunal noted that these events happened after the commencement of the investigation into the misconduct subsequently found by the 2023 Tribunal. The Tribunal noted that they were not accompanied by any acknowledgement of misconduct or admissions and Dr Monro had not stated that she had decided to cease to practise because she recognised the concerns raised about her fitness to practise. The Tribunal noted that

while this had protected the public to date, it had not been accompanied by insight on the part of Dr Monro concerning her misconduct or its potential impact upon the public. The Tribunal noted that Dr Monro continued to work as a naturopath at, and continued to act as a director of, Breakspear Medical. The Tribunal was therefore of the view that Dr Monro's retirement and stated intentions did not amount to mitigating factors.

235. The Tribunal then considered whether any aggravating factors were present.

236. The Tribunal considered that paragraphs 52a and 52c of the SG were engaged:

> *'52 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'*

237. The Tribunal noted that to date Dr Monro had not presented any evidence of insight regarding the misconduct found by the 2023 Tribunal or this Tribunal. Moreover, Dr Monro has not provided any evidence that she has reflected on that misconduct or sought to apologise for it to those affected. Neither has she acted upon the suggestion made by the 2023 Tribunal that a review Tribunal would be assisted by her reflections on its findings. The Tribunal was of the view that Dr Monro's continued lack of insight into the misconduct found proved by the 2023 Tribunal and the lack of evidence of insight concerning the misconduct found proved by this Tribunal were aggravating features.

238. The Tribunal was particularly concerned about the lack of insight given that each incident of misconduct concerned a young child. Such patients are inherently vulnerable simply by virtue of their age. The Tribunal reminded itself that both cases involved the provision of unconventional treatment to children.

239. The Tribunal considered each sanction in ascending order of severity starting with the least restrictive.

No action

240. The Tribunal first considered whether to conclude the case by taking no action. It noted that taking no action following a finding of impaired fitness to practise would only be appropriate in exceptional circumstances. The Tribunal noted that taking no action would result in Dr Monro being able to return to unrestricted practice once her period of suspension had expired.

241. The Tribunal determined that there were no exceptional circumstances in this case which would justify taking no action. In reaching this conclusion, the Tribunal specifically considered the emails submitted by, and on behalf of Dr Monro, stating that she had retired, had relinquished her licence and did not intend to practise as a doctor in the future. At the impairment stage the Tribunal determined that Dr Monro lacked insight into her actions. It also noted that Dr Monro could return to practice despite her stated intentions. The Tribunal understood that Dr Monro works as an environmental naturopath at Breakspear Medical Group, albeit not as a doctor. The Tribunal therefore determined that taking no action would be neither appropriate nor sufficient to protect the public interest.

Conditions

242. The Tribunal next considered whether it would be sufficient to impose conditions on Dr Monro's registration. It has borne in mind that any conditions imposed would need to be appropriate, proportionate, workable and measurable.

243. The Tribunal concluded that for conditions to be workable, a doctor had to recognise their failings, understand why conditions were required and engage with the GMC to ensure conditions are complied with.

244. The Tribunal noted its own conclusion that there is no evidence that Dr Monro has developed any insight into her failings. Moreover, Dr Monro has not engaged with the GMC or the MPTS in relation to the proceedings of the 2023 Tribunal or the current proceedings. There is no evidence that Dr Monro would comply with any conditions imposed upon her. Furthermore, the Tribunal considered that public confidence in the profession and its regulator would be undermined if conditions were imposed, given the gravity of the misconduct found proved and having regard to the age of the patients concerned. The Tribunal therefore determined that it would not be possible to formulate any workable or appropriate conditions which would adequately address the concerns in this case.

Suspension

245. The Tribunal then went on to consider whether suspending Dr Monro's registration would be appropriate and proportionate.

246. The Tribunal took account of paragraphs 93, 94, and 97a of the SG regarding suspension.

> ''***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.

94 *Suspension is also likely to be appropriate in a case of deficient performance or lack of knowledge of English in which the doctor currently poses a risk of harm to patients but where there is evidence that they have gained insight into the deficiencies and have the potential to remediate if prepared to undergo a rehabilitation or retraining programme.*

97 *Some or all of the following factors being present (this list is not exhaustive) would indicate suspension may be appropriate.*

a *A serious departure from Good medical practice, but where the misconduct is not so difficult to remediate that complete removal from the register is in the public interest. However, the departure is serious enough that a sanction lower than a suspension would not be sufficient to protect the public.''*

247. The Tribunal reminded itself that there was no evidence of remediation or any steps having been taken by Dr Monro to address the misconduct found by this Tribunal. Further, there had been no evidence of any progression in Dr Monro's insight during the last 12 months. The Tribunal considered that Dr Monro had provided no evidence that she had insight into any of the misconduct found proved.

248. The Tribunal considered that while in principle the failings identified by both Tribunals were capable of being addressed, that could only be the case where a doctor engaged with the regulatory process, reflected on their failings, and took steps to remediate. Dr Monro has not engaged meaningfully and there is no evidence of reflection or remediation. Dr Monro's position was that because she had retired, she would not engage with the process. The Tribunal concluded that this showed a lack of regard for the purpose and importance of the regulator whose concern is not merely the individual doctor but the maintenance of professional standards and public confidence in the profession.

249. The Tribunal also considered that as a result of her retirement, Dr Monro's skills as a doctor will have declined. She has been out of practice for at least two years.

250. The Tribunal determined that to impose a period of suspension would not adequately uphold the overarching objective to protect the public or uphold proper professional standards.

Erasure

251. The Tribunal considered the factors set out at paragraph 109 of the SG that indicate erasure is the appropriate sanction, and found the following to be of relevance:

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

252. This Tribunal found that there had been overlapping and multiple breaches of GMP in relation to vulnerable patients. Moreover, this Tribunal has no evidence either that Dr Monro recognises this, or that she has developed insight into the seriousness of her misconduct or the potential risk of harm to patients. This Tribunal therefore concluded that there is a real concern that Dr Monro showed a reckless disregard for the principles in GMP.

253. The Tribunal was mindful that the misconduct which was found proved at the 2023 Tribunal had the possibility to be remediated. However, Dr Monro did not engage with those proceedings, has not taken the opportunity provided through 12 months of suspension from practice to learn from her misconduct and reflect upon it and has not engaged with these proceedings. This Tribunal concluded that she has provided no evidence of any insight into her misconduct and has made no effort to remediate. The Tribunal therefore concluded that Dr Monro demonstrated a persistent lack of insight into the seriousness of her actions and their consequences, both for her patients and for public confidence in the profession.

254. The Tribunal bore in mind the impact that erasure would have on Dr Monro. In this regard, the Tribunal considered that the impact would be relatively limited given Dr Monro's decision to retire at least 2 years ago. The Tribunal balanced the potential impact of erasure against the purpose of the overarching objective, namely to protect the public, promote and maintain standards and maintain public confidence in the profession. The Tribunal concluded, however, that erasure was the necessary, appropriate and proportionate sanction in this case. The Tribunal found that Dr Monro has been given opportunities to show insight and remediate the concerns about her practice, however she has shown no willingness to engage and provided no evidence that she is fit to return to practice. The Tribunal determined that a sanction of erasure would also convey to the profession that demonstrating continued disengagement with the GMC and persistent lack of insight into serious misconduct risks serious consequences.

255. The Tribunal therefore determined to erase Dr Monro's name from the medical register.

Determination on Immediate Order - 16/08/2024

256. Having determined that Dr Monro's name should be erased from the medical register, 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

257. On behalf of the GMC, Mr Hamlet submitted that an immediate order is required in this case. He referred the Tribunal to the relevant paragraphs of the SG and its own determination on Sanction. He submitted that an immediate order is necessary to protect patient safety, maintain professional standards and public confidence in the profession. He submitted that the findings of the Tribunal are serious, have led to a substantive sanction of erasure, and that an immediate order should be imposed in this case.

258. There were no written submissions provided by Dr Monro regarding immediate order.

The Tribunal's Determination

259. In reaching its decision, the Tribunal considered the relevant paragraphs of the SG and exercised its own independent judgment. In particular, it took account of paragraphs 172, 173 and 178:

> '*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.*
>
> *…*
>
> *178* *Having considered the matter, the decision whether to impose an immediate order will be at the discretion of the tribunal based on the facts of each case. The tribunal*

should consider the seriousness of the matter that led to the substantive direction being made and whether it is appropriate for the doctor to continue in unrestricted practice before the substantive order takes effect.'

260. The Tribunal noted that there were concerns about potential risk to patient safety. It was of the view that public confidence would be undermined if Dr Monro was permitted to practise unrestricted, given the serious nature of Dr Monro's misconduct. Furthermore, the Tribunal concluded that an immediate order was necessary to maintain and uphold professional standards given the conclusions reached in its determination on sanction.

261. This means that Dr Monro's registration will be suspended from the date on which notification of this decision is deemed to have been served upon her. The substantive direction, as already announced, will take effect 28 days from that date, unless an appeal is made in the interim. If an appeal is made, the immediate order will remain in force until the appeal has concluded.

262. There is no interim order to revoke

263. That concludes this case.

ANNEX A - 22/05/2024

Service and Proceeding in Absence

Service

264. Dr Monro is neither present nor represented at this hearing.

265. The Tribunal was provided with a copy of a Service bundle from the General Medical Council (GMC). This included a screenshot of the contact information held for Dr Monro on the GMC system, namely her registered postal address and email address.

266. The bundle also included the GMC information letter, which included the Allegation, and the Medical Practitioners Tribunal Service (MPTS) notice of hearing letter. The emails/letters were all dated 8 April 2024 and were sent to Dr Monro by email and by post to her registered address.

267. In respect of the GMC letter, there was an email read receipt dated 8 April 2024 from Ms F, PA & Medical Secretary for Breakspear Medical Group Ltd. Dr Monro replied, via Ms F', to the GMC email on 11 April 2024 stating that she had received the letter at her home address on the evening of 10 April 2024.

268. In respect of the MPTS letter, there was an email read receipt dated 8 April 2024 from Ms F. The Tribunal was provided with Royal Mail Track and Trace documentation. This showed that delivery of the MPTS letter was *"collected by the customer"* from a Post Office on 13 April 2024.

269. Mr Hamlet, Counsel on behalf of the GMC, submitted that notice had been served and responded to directly. He stated that this was a case where Dr Monro is clearly aware of the proceedings generally and that she and XXX, Mr D, have both previously responded confirming an intention not to engage with the GMC at all. Mr Hamlet stated that Dr Monro has provided a response to the allegations. He stated that Dr Monro does not intend to engage any further with the GMC as she has retired from medicine and will turn XXX years old during the proceedings. Mr Hamlet submitted that the requirements of service had been effected and the Tribunal has clear reasons why Dr Monro is absent.

270. The Tribunal noted that the correspondence sent to Dr Monro contained the relevant information and that her response indicates that she is well aware of these proceedings. The Tribunal also had regard to the correspondence from Dr Monro via [Mr D], in which she is clear of the date of this hearing and set out that she would not be attending it. Although mention is made in this email of Dr Monro's age, neither she nor [Mr D] suggest that there is any reason why she could not attend the hearing virtually nor any indication that she is experiencing any ill health.

271. The Tribunal therefore determined that notice of this hearing had been served on Dr Monro in accordance with Rule 40 of the GMC's (Fitness to Practise) Rules 2004, as amended, ('the Rules'), and paragraph 8 of Schedule 4 to the Medical Act 1983, as amended.

Proceeding in Absence

272. The Tribunal then went on to consider whether it would be appropriate to proceed with this hearing in Dr Monro's absence pursuant to Rule 31 of the Rules. The Tribunal was conscious that the discretion to proceed in the absence of a doctor should be exercised with the appropriate care and caution, balancing the interests of the doctor with the wider public interest.

273. The Tribunal was provided with further documentation. This included an email dated 3 October 2023 from the MPTS Case Management Team to Dr Monro inviting her to participate in the MPTS case management procedure and provided details of the First Listing Telecon (FLTC). Mr D, XXX and Registered Manager/Managing Director at Breakspear Medical Group Ltd, replied by email on 10 October 2023. He stated:

> *"Jean Monro has retired from the practise of medicine; she surrendered her licence to practise more than 2 years ago, she has also twice applied for 'voluntary erasure' and her membership with the General Medical Council lapsed at the end of 2021.*
>
> *Jean Monro does not propose to engage any further with the GMC or the MPTS."*

274. On 15 February 2024 the GMC emailed Dr Monro with a bundle of documents in advance of the Pre-Hearing Meeting (PHM), which included the Rule 7 and 8 letters and a GMC expert report.

275. The notes of the MPTS FLTC and PHM were sent to Dr Monro by email on 19 October 2023 and 29 February 2024, respectively.

276. On 29 February 2024 the GMC emailed Dr Monro with a copy of a signed witness statement and confirmed that a supplementary expert report would be sought by the GMC. There was an email read receipt from Ms F dated 29 February 2024. Mr D replied by email on 6 March 2024. He stated that Dr Monro did not intend to engage any further with the GMC because she had retired from the practice of medicine and also referred to Dr Monro's age. He stated that Dr Monro had discussed Patient A's case with the doctors and other members of their Clinical Governance Committee and the news that the GMC had decided to take this matter to a MPTS hearing *"was poorly received by the committee members"*. Mr D stated:

> *"A negative outcome of your Hearing would indicate that Breakspear Medical has breached several requirements under CQC legislation, Safeguarding legislation and this would reflect very poorly on Breakspear Medical. I am a member of the Governance Committee as the CQC Registered Manager of Breakspear Medical.*
>
> *I write to you to ask if you would be prepared to invite me to comment further on this case."*

The Tribunal was satisfied that Mr D was acting as his mother's agent and with her knowledge and consent in all his communications with the GMC concerning these proceedings.

277. On 18 March 2024 the GMC emailed Dr Monro with a copy of the supplementary expert report and confirmed that GMC evidence disclosure was complete. There was an email read receipt from Ms F dated 26 March 2024. Further correspondence was sent by email to Dr Monro by the GMC on 26 March 2024, which included the draft hearing bundle. There was an email read receipt from Ms F dated 26 March 2024.

278. Mr D provided a letter from Dr Monro by email to the GMC on 12 April 2024. The GMC responded on 18 April 2024 and stated that Dr Monro's response to the Rule 15 Allegations would be shared with the GMC expert and included in the final hearing bundle. On 30 April 2024 the GMC emailed Dr Monro to confirm that it had received no further comments from her and so had finalised the hearing bundle. There was an email read receipt from Ms F dated 1 May 2024.

279. Mr Hamlet invited the Tribunal to proceed with this hearing in Dr Monro's absence. Further to the comments he made above, Mr Hamlet submitted that it would also be fair to proceed with this hearing in Dr Monro's absence.

280. In deciding whether to proceed with this hearing in Dr Monro's absence, the Tribunal carefully considered all the information before it, including the service documentation, Mr Hamlet's submissions, and Dr Monro's correspondence.

281. The Tribunal took into account all of the factors identified in *R v Jones* [2002] UKHL 5. It balanced Dr Monro's interests with the public interest in deciding whether to proceed in her absence and carefully considered whether a fair hearing could take place in the absence of Dr Monro and/or any legal representative instructed on her behalf.

282. The Tribunal were completely satisfied that Dr Monro has chosen to absent herself, that she is aware of her right to legal representation, that she is aware of the potential adverse consequences to her and the business of which she was formerly the Medical Director. The Tribunal noted that Mr D's response did not request an adjournment on behalf of Dr Monro but reiterated her intention not to engage with these proceedings. The Tribunal concluded that an adjournment would not serve any purpose given the clear indication by Dr Monro that she did not wish to engage with the proceedings. The Tribunal also took into

account Mr Hamlet's submissions that the Tribunal itself could formulate questions based upon such response to the Allegation as Dr Monro has provided to put to any witnesses.

283. This case relates to a child and the Tribunal also considered that it is in the interests of that child and their parents that matters are brought to a conclusion given the age of the Allegation. Mr D having raised the issue of Dr Monro's age, the Tribunal also considered that reaching a conclusion without further delay was also likely to be in her interests. In all of the circumstances and in accordance with Rule 31 of the Rules, the Tribunal therefore determined that the public interest in this hearing proceed expeditiously and without delay outweighed any prejudice or disadvantage which might be experienced by Dr Monro, who has deliberately chosen not to engage with the proceedings.

ANNEX B - 22/05/2024

Application to amend the Allegation

284. On 22 May 2024 Mr Hamlet made an application on behalf of the GMC for amendment of the Allegation under Rule 17(6) of the Rules, which states:

> *"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."*

285. The proposed amendments were as follows:

> *1. Between 30 April 2020 and 18 November 2020 you were involved in the care and treatment of Patient A. You failed to provide good clinical care in that you:*
>
> *a. did not take an environmental history to establish whether there were any ongoing risks of exposure to fungal or other toxins in Patient A's environment, including from:*
>
> *i. ongoing exposure to moulds;*
>
> *ii. consumption of foods potentially high in Ochratoxin A ('OTA');*
> *…*

f. provided information to Patient A's parents based on the Test's laboratory report ('the Report'):

i. which asserted that the Test was done in a ~~CILA~~ CLIA approved laboratory before verifying that it was accredited;

…

iii. without alerting them to:

…

2. the fact that it was performed in a laboratory that did not conform to NHS standards;

3. the fact that it was not approved in the United States;

Submissions

286. Mr Hamlet stated that there was sensitivity around amending the Allegation in circumstances where the practitioner was not present and therefore could not respond to the proposed amendments. He stated that he had carefully considered the position and whether any amendment could be made without injustice. Mr Hamlet submitted that the proposed amendments were preferable but not essential. He submitted that Dr Monro had responded to the Allegation in detail. He invited the Tribunal to conclude that Dr Monro had not had any difficulty understanding the paragraphs as currently framed. He therefore submitted that no unfairness would be caused by the proposed amendments.

287. In terms of paragraph 1(a) of the Allegation, Mr Hamlet submitted that adding the word *"from"* would be preferable to improve the clarity of this paragraph of the Allegation.

288. In respect of paragraph 1(f)(i) of the Allegation, Mr Hamlet stated that this was simply correction of a typo in changing *"CILA"* to *"CLIA"*.

289. In terms of sub-paragraphs 1(f)(iii)(2) and (3) of the allegation, Mr Hamlet referred to the stem of that paragraph and stated that, on reflection, both would benefit from the addition of the words *"the fact"* at the start of each sub-paragraph. Mr Hamlet submitted that this proposed amendment was not essential but may be preferable. He stated that the amendment did not change the case against Dr Monro and she had responded in any event.

The Relevant Legal Principles

290. The Legally Qualified Chair (LQC) gave legal advice to the Tribunal. She reminded the Tribunal that it has a discretion to allow amendment to any part of an Allegation. She stated that the key criteria for amendment is, whether in allowing it, it will result in injustice: in other words can Dr Monro still have a fair hearing if the amendment is permitted.

291. The LQC stated that the later and/or more substantial the change then the more likely it is to cause injustice. She stated that Dr Monro has the right to have sufficient and proper notice of the Allegation and it should be sufficiently particularised well before a hearing to enable her to know clearly what she is alleged to have done or failed to do and in what respect she failed.

292. The LQC stated that the key question was whether the risk of injustice could be met despite Dr Monro's absence and lack of representation. In considering this, the Tribunal can take into account the nature of the change proposed, whether that affects the substance of the paragraph of the Allegation, whether it provides additional clarity to assist proper understanding of the paragraph by those who read it and whether there is any evidence that Dr Monro's understanding of the paragraph, or such responses as she has provided, would be adversely affected or changed by the amendments. In this regard, the LQC stated that the Tribunal was entitled to consider the letter from Dr Monro dated 12 April 2024 in which she responded to the Allegation as it currently stands.

Tribunal's Decision

293. The Tribunal considered whether it would be unfair to make the amendments to the Allegation proposed by the GMC. It considered whether the proposed amendments were of substance or just form, and whether they would assist in terms of clarity.

294. The Tribunal noted the submissions of the GMC that the amendments to the Allegation are preferable rather than essential but would improve its clarity. It determined that, as suggested by Mr Hamlet, the proposed amendments were not substantial in their nature.

295. The Tribunal had particular regard to Dr Monro's response to the Allegation in her letter to the GMC dated 12 April 2024. The Tribunal was of the view, as a result, that Dr Monro clearly understood what these paragraphs of the Allegation set out and had responded to them in a way which showed that she had understood their content.

296. In all the circumstances, the Tribunal determined to grant the GMC's application for amendment of the Allegation as set out above. The Tribunal was of the view that the amendments would not change the nature of the case but would ensure clarity such that the paragraphs of the Allegation could be properly understood by any person reading it. The Tribunal concluded that there was no unfairness or injustice to Dr Monro in allowing the amendments sought, particularly given their limited nature and in view of the responses received from her.

ANNEX C - 03/06/2024

Service and Proceeding in Absence (Review)

Service

1. Dr Monro is neither present nor represented at this hearing. The Tribunal has considered service and whether to proceed in Dr Monro's absence in respect of the new aspect of this case. This decision can be found at Annex A. The Tribunal, having now been made aware of the review aspect of Dr Monro's case, considered service and proceeding again.

2. The Tribunal was provided with a copy of a Service bundle from the GMC in respect of the review aspect of this hearing. This included a screenshot of the contact information held for Dr Monro on the GMC system, namely her registered postal address and email address.

3. The bundle also included the GMC information letter dated 26 March 2024 and the MPTS notice of hearing letter dated 8 April 2024. The unredacted sections of the correspondence referred to the review aspect of this hearing.

4. As already set out in Annex A and in respect of the MPTS letter, there was an email read receipt dated 8 April 2024 from Ms F. The Tribunal was provided with Royal Mail Track and Trace documentation. This showed that delivery of the MPTS letter was *"collected by the customer"* from a Post Office on 13 April 2024.

5. In respect of the GMC correspondence, and in addition to Annex A, the draft review hearing bundle was sent by email to Dr Monro on 26 March 2024. There was an email read receipt dated 26 March 2024 from Ms F. On 30 April 2024, the GMC wrote to Dr Monro to confirm that it had finalised the hearing bundle and that the review bundle would only be provided to the Tribunal at the impairment stage of the hearing.

6. On behalf of the GMC, Mr Hamlet stated that the Tribunal was now seeing an unredacted version of the correspondence referred to at Annex A, and invited the Tribunal to make the same conclusions as at Annex A.

7. The Tribunal noted the unredacted sections of the correspondence and the full documentation and reasoning it detailed at Annex A.

8. The Tribunal determined that notice of the review aspect of this hearing had been served on Dr Monro in accordance with Rule 40 of the Rules, and paragraph 8 of Schedule 4 to the Medical Act 1983, as amended.

Proceeding in Absence

9. The Tribunal then went on to consider whether it would be appropriate to proceed with this hearing in Dr Monro's absence pursuant to Rule 31 of the Rules. The Tribunal was conscious that the discretion to proceed in the absence of a doctor should be exercised with the appropriate care and caution, balancing the interests of the doctor with the wider public interest.

10. On behalf of the GMC, Mr Hamlet again drew on the material referred to at Annex A. He stated that Dr Monro is fully aware of these proceeding and has clearly expressed that she will not attend this hearing now, or at any future time. Mr Hamlet invited the Tribunal to consider that it was appropriate to proceed with this hearing in Dr Monro's absence.

11. In deciding whether to proceed with this hearing in Dr Monro's absence, the Tribunal carefully considered all the information before it, including the service documentation, Mr Hamlet's submissions, and Dr Monro's correspondence that was referred to in Annex A.

12. The Tribunal noted the unredacted sections of the correspondence and the full documentation and reasoning it detailed at Annex A. The Tribunal noted that Dr Monro did not attend the previous 2023 Tribunal hearing and so clearly understands the implications of these proceedings.

13. The Tribunal took into account all of the factors identified in *R v Jones* [2002] UKHL 5, as before. It balanced Dr Monro's interests with the public interest in deciding whether to proceed in her absence and carefully considered whether a fair hearing could take place in the absence of Dr Monro and/or any legal representative instructed on her behalf.

14. In all of the circumstances and in accordance with Rule 31 of the Rules, the Tribunal determined that Dr Monro had voluntarily absented herself, an adjournment would not serve any purpose given the clear indication by Dr Monro, that she did not wish to engage with the proceedings, and there was a public interest in this hearing proceeding expeditiously and without delay. As such, the Tribunal determined to proceed in Dr Monro's absence in respect of the review matters.

ANNEX D - 05/06/2024

Extension of current sanction

1. On day nine, before the Tribunal began its consideration on the basis of the facts which it has found proved whether Dr Monro's fitness to practise is impaired by reason of misconduct, the question of adjourning the hearing part heard was raised. This was because both the Tribunal and the GMC were concerned about whether there was sufficient time to conclude the hearing in the remaining time allotted for this case.

2. Consequently, the Tribunal invited submissions as to whether the current sanction should be extended pending final resolution of the case on a later date.

Submissions

3. On behalf of the GMC, Mr Hamlet submitted that there was not enough time remaining in the listing to make a substantive finding as to current fitness to practise before going part-heard.

4. Mr Hamlet submitted that therefore the Tribunal should firstly, adjourn the hearing part-heard under Rule 29 of the Rules, and secondly, extend the existing order of suspension under Rule 35(D) of the Medical Act 1983.

5. Mr Hamlet stated that the basis upon which the Tribunal should extend the order should not be made on the basis of an assessment of whether Dr Monro's fitness to practise is impaired, rather the Tribunal should simply adopt the rationale that was applied by the original 2023 Tribunal, which had imposed the suspension in relation to the current review matters.

6. Mr Hamlet further submitted that the existing order of suspension was appropriate and necessary to uphold proper professional standards and to maintain public confidence in the profession and that it was a proportionate response in all the circumstances.

7. Mr Hamlet therefore invited the Tribunal to extend the current suspension imposed upon Dr Monro's registration on the same basis as that identified by the 2023 Tribunal until such time as the Tribunal can reconvene and substantively consider the issue and complete the hearing as a whole.

8. Dr Monro was not present or represented. There were no written submissions from Dr Monro regarding extension of the sanction.

The Relevant Legal Principles

9. The Legally Qualified Chair (LQC) gave legal advice to the Tribunal. She stated that, pursuant to Rule 29(2) of the Rules, a tribunal has the power to adjourn a case which has been opened on application or of its own motion.

10. The LQC stated that it matters not in this particular case whether this is an application made by the GMC or initiated by the Tribunal itself.

11. Regrettably, delay had been occasioned during the case due to unforeseeable factors relating to one of the Tribunal members. In this case this had resulted in the MPTS substituting that Tribunal member with an alternative. This was because of the nature of the issue which had arisen as well as the complexity of the case, the potentially long period of adjournment had the original Tribunal constituted remained, and the interests of justice.

12. It is a matter for the Tribunal, subject only to the general common law rule, that it must act fairly when determining whether an adjournment is appropriate. In considering this, the Tribunal should take into account factors such as the age of the registrant, the doctor's engagement with the process, the length of the adjournment and the complexity of the case, and whether after any adjournment, the Tribunal can still reach a fair determination.

13. The exercise of the Tribunal's determination, in relation to the Review hearing is subject to the same common law rule of fairness, so the same considerations apply to that decision.

14. The Tribunal must have regard to the overarching objective in exercising its functions, which is the protection of the public, and that involves the pursuit of the following objectives 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 maintain and promote proper professional standards and conduct for members of that profession. As the key issue for both hearings to consider will be current impairment and then, if appropriate, sanction, it is apparent that these two matters should be considered at the same time.

15. Rule 22(5) of the Rules states that where a review hearing is adjourned prior to a tribunal making a finding, in this case in respect of impairment, the Tribunal must consider whether to make a direction under section 35D(5)(a) of the Medical Act 1983 that the current period of suspension can be extended for such further period of time as may be specified in any direction. The Tribunal cannot suspend for more than an additional 12 months.

16. Any decision the Tribunal makes must be proportionate having regard to all the circumstances.

17. The Tribunal accepted the LQC's advice.

Tribunal's Decision

18. The Tribunal did not have sufficient time to conclude the hearing in the time remaining. As such, it determined to adjourn this hearing part heard.

19. The Tribunal noted that the order of suspension on Dr Monro's registration is due to expire on 6 June 2024.

20. The Tribunal referred to paragraph 170 of the Sanctions Guidance:

> *'Where a review hearing cannot be concluded before the conditional registration or suspension expires, the tribunal can extend it for a short period. [footnote Section 35D (5) and (12) Medical Act 1983 as amended]. This would allow for relisting of the review hearing as soon as practicable and to maintain the status quo before the outcome of the review hearing'.*

21. It determined that the public interest could not allow Dr Monro to remain without sanction until the hearing had been concluded given the proven facts of the new hearing and her current impaired fitness to practise in relation to her Review hearing.

22. The Tribunal noted that the doctor is retired, however, it further noted that she could return to practise if a restriction was not placed on her registration. It concluded that allowing Dr Monro to return to unrestricted practise in the current circumstances would not be consistent with the Tribunal's duty to protect the public and maintain proper professional standards.

23. In considering whether it was proportionate to extend the period of suspension, the Tribunal took into account that the decision of the MPTS to substitute another Tribunal member to deal with the balance of the new substantive matter resulted in a shorter period of adjournment. As the hearing is being adjourned until after the date on which the suspension would otherwise expire, the Tribunal determined under section 35D(5)(a) of the Medical Act 1983 to extend the current order of suspension on Dr Monro's registration for a period of three months from the expiry of the current order of suspension on 6 June 2024.

24. The MPTS will send Dr Monro a letter informing her of her right of appeal and when the new sanction will come into effect. The current order of suspension will remain in place during the appeal period.