COUNCIL FOR HEALTHCARE REGULATORY EXCELLENCE

NOTE OF CASE MEETING ON 20 JULY 2005

AT 11 STRAND, LONDON WC2N 5HR

Re: Dr Alan Roy Williams

PRESENT: Jonathan Asbridge (Regulator Member & Chair) (President, Nursing & Midwifery Council)
Hew Mathewson (Regulator Member) (President, General Dental Council)
Frances Dow (Lay Member) (retired Vice Principal, University of Edingburgh)

IN ATTENDANCE: Professor Julie Stone (Deputy Director, CHRE)
Michael Andrews (Fitness to Practise Manager)
Len Murray, Associate, Baker & McKenzie (Legal Adviser)
Andrew Hill, Associate, Baker & McKenzie

AS OBSERVERS: Marianne Cowpe (Registrant Member, Nursing & Midwifery Council)
Rhiannon Seddon, Summer Clerk, Baker & McKenzie

Definitions

In this note, the following abbreviations will apply:

"CHRE"	Council for Healthcare Regulatory Excellence
"the Council"	CHRE as constituted at its meeting on 20 July 2005
"the FPP"	Fitness to Practise Panel of the GMC
"the GMC"	General Medical Council
"Dr Williams"	Dr Alan Roy Williams MB BS FRCPath
"the Act"	*NHS Reform and Healthcare Professions Act* 2002

The FPP's determination

The Council considered whether the determination of the FPP of the GMC on 3 June 2005 to find Dr Williams guilty of serious professional misconduct ("SPM") and to impose conditions upon his registration as a medical practitioner for 3 years should be referred to the High Court under section 29 of the Act.

Dr Williams was at all material times employed as a Consultant Histopathologist at Macclesfield District General Hospital and was a Forensic Pathologist accredited by the Home Office Policy Advisory Board for Forensic Pathology. On 16 December 1996, Dr Williams performed a post mortem examination on Christopher Clark, aged 12 weeks, at the request of HM Coroner for Cheshire (in his capacity as a consultant histopathologist). On 27 January 1998, Dr Williams performed a post mortem examination on Harry Clark, aged 8

weeks, at the request of the Cheshire Police (in his capacity as a forensic pathologist accredited by the Home Office).

On 9 November 1999, Mrs Clark, the mother of Christopher and Harry, was convicted by a majority of 10 to 2 of their murder. Dr Williams's post mortem reports were in evidence at the trial and he was also called to give evidence as an expert witness by the Crown.

On 29 January 2003, upon appeal by Mrs Clark, the Court of Appeal concluded that Mrs Clark's convictions for murder were unsafe, allowed her appeal and quashed her convictions.[1]

Documents

The following documents were before the Council:

1. Report prepared by Baker & McKenzie dated 13 July 2005;
2. Determination of the FPP dated 3 June 2005;
3. Transcripts of the FPP hearing (from 24 January 2005 to 3 June 2005)(32 days);
4. Exhibits (available at the meeting); and
5. Certain correspondence received by CHRE from third parties since the FPP's Determination, as follows:
   (a) Email dated 7 June 2005 from Ellen Thomson;
   (b) Email dated 8 June 2005 from Jane Alexander;
   (c) Email dated 8 June 2005 from Paul Jermy;
   (d) Email dated 9 June 205 from Penny Mellor;
   (e) Further email dated 9 June 2005 from Penny Mellor; and
   (f) Email dated 12 June 2005 from Penny Mellor;
   (together "the Third Party Correspondence").

The Council noted that it had seen the Third Party Correspondence. However, the Council was mindful that, in considering the FPP's determination, it should treat with caution any material which was not before the FPP and which the parties had not seen. The Third Party Correspondence was therefore before the Council as background material, rather than forming part of its consideration of specific issues.

Conflicts of Interest

[1] The judgment of the Court of Appeal, delivered on 11 April 2003, is reported as *R v Clark (Sally) (Appeal against Conviction) (No 2)* [2003] EWCA Crim 1020.

The Chair informed the Council that the members convened had no apparent conflicts of interest and no conflicts of interest were registered.

Matters noted by the Council

The Council noted the matters set out below:

The FPP's findings of fact

1. The FPP's determination was based, together with the heads of charge which Dr Williams had already admitted, on the following significant findings of fact on the non-admitted heads of charge[2]:

Head	Finding
Clinical Conduct with respect to Christopher	
3(f)(i) & (ii)	Histology did not show any or any significant focal acute inflammation of the lung and inflammation of the spleen, contrary to Dr Williams's report.
3(h)	Dr Williams failed to exercise reasonable care and skill in interpreting and/or reporting upon the slides of the lungs and spleen.
3(i)(i)-(iv)	In Dr Williams's report: • he failed to discuss the possible significance of his reported findings of certain bruising and a split upper frenulum; • he failed adequately to discuss the possible causes of death; • he gave the cause of death as "1a) Lower respiratory tract infection" when this did not have a proper scientific basis; and • he should have given the cause of death as "Unascertained".
4(a) & (b)	Dr Williams failed to discharge the duties of a competent pathologist in such circumstances and his post mortem consideration and treatment of Christopher was such that it impaired the reliable evaluation of the evidence of the cause of Christopher's death.

[2] This reflects the analysis of Counsel for Dr Williams of the heads of charge into, on the one hand, charges concerning Dr Williams's clinical conduct of the post mortem examinations of Christopher and Harry, and, on the other, charges concerning Dr Williams's conduct in relation to the non-disclosure of Harry's microbiology results.

Head	Finding
8(a) & (b)	In his report, written statement and oral evidence relating to Christopher, Dr Williams was incompetently self-contradictory and failed to use his best endeavours to express fair, accurate and objective expert opinions.
9(c)(ii)	Having removed the eyes and taken a sample of vitreous humour before laboratory dissection and/or block selection, Dr Williams thereby risked the compromise of the quality of the resultant microscope slides and/or any subsequent specimens from the eyes.
9(d)(iv)	Having conducted the laboratory dissection and subsequent block selection of the eyes, Dr Williams thereby risked the compromise of the quality of the resultant microscope slides and/or any subsequent specimens from the eyes.
9(g)	Dr Williams, in certain circumstances, was inadequate in his post mortem consideration and treatment of the eyes.
10(g)	Dr Williams's conclusions upon microscopically examining the histology that there was some subdural haemorrhage of the spinal cord and that there was acute inflammation and bruising in the paraspinal muscles were incorrect.
10(h)	Dr Williams was not competent to conduct microscopic examination of the spinal cord and/or paraspinal muscles to the level of expertise appropriate and necessary for a forensic case of this nature.
10(i)	Dr Williams was, in certain circumstances, incompetent in his post mortem consideration and treatment of the spinal cord and/or paraspinal muscles.
11(b)(i)	Dr Williams should have submitted the brain to an expert in neuro-pathology for laboratory dissection and/or block selection.
11(b)(iv)	Having fixed the brain and subsequently conducted the laboratory dissection and block selection, Dr Williams thereby risked the compromise of the quality of the resultant microscope slides.
11(c)(iii)	Dr Williams's conclusion upon microscopically examining the histology that there were "occasional contusional tears in the brain containing red blood cells (ie not artefactual)" (meaning, not caused by the post mortem process) was incorrect.
11(d)	Dr Williams was not competent to conduct dissection and block selection and/or microscopic examination of the brain to the level of expertise appropriate and necessary for a forensic case of this nature.
11(e)	Dr Williams was, in certain circumstances, incompetent in his post mortem consideration and treatment of the brain.
12(i)	Dr Williams was, in certain circumstances, incompetent in his post mortem consideration and treatment of the ribs.

Head	Finding
12(j)	In certain respect, Dr Williams failed to use his best endeavours to provide comprehensive expert advice in advance of Mrs Clark's trial.
13	In certain respects, Dr Williams's post mortem consideration and treatment of Harry was such that it impaired the reliable evaluation of the evidence of the cause of his death.
17(b)	The microbiology and/or biochemistry results were relevant to and/or tended to cast doubt upon Dr Williams's report that there was no evidence of, or evidence which might suggest, acute infection or inflammation including meningitis.
17(c)(i) - (ii)	Versions 1, 2, 3 and 4 (of Dr Williams's reports) and/or each of them were not fair, comprehensive, accurate or objective in that: • they omitted reference to and discussion of the microbiology and biochemistry results, particularly the presence of staphylococcus aureus in the cerebro-spinal fluid and elsewhere, polymorphs and elevated protein; and • they wrongly implied that the microbiology and biochemistry results were neither evidence of nor contained evidence which might suggest acute infection or inflammation including meningitis.
17(d)	By his conduct, Dr Williams wrongfully failed and/or chose not to refer to the microbiology or biochemistry results in Versions 1, 2, 3 or 4.
18(a) - (g)	Dr Williams wrongfully failed and/or chose not to disclose the microbiology and/or biochemistry results: • to HM Coroner (microbiology only); • at the second post mortem examination of Harry performed by Dr Rushton and Professor Emery; • in response to a certain letter from solicitors acting for the child the subject of the Care Proceedings; • to the Court, at the committal proceedings; • when Professors Berry and David visited him at Macclesfield in connection with the Care Proceedings; • at a meeting of experts in the Care Proceedings; and • otherwise in the Care Proceedings.

Head	Finding
19(a)(i) - (iii)	In his capacity as an expert witness for the Crown, Dr Williams was under a duty to share the fact and/or arguable significance of the results of the microbiology and/or biochemistry tests with: • the Police and/or the Crown Prosecution Service; • the experts instruction on behalf of the Crown (except perhaps Professor Green); • the experts instructed on behalf of Mrs Clark.
19(b)(i) - (iv)	Dr Williams wrongfully chose not to or failed to share the fact and/or arguable significance of the results of the microbiology and/or biochemistry tests with: • the Police and/or the Crown Prosecution Service; • the experts instruction on behalf of the Crown (except perhaps Professor Green); • the experts instructed on behalf of Mrs Clark; and • the Court.

The FPP's finding of SPM

2. Having made the above findings of fact, the FPP went on to find (in summary):

(a) There was no evidence that Dr Williams had wilfully failed to disclose results of tests, had exhibited malice nor had an intention to mislead.

(b) However, whatever his own views, even if reasonable, Dr Williams had a responsibility as an experienced forensic pathologist to consider whether the test results might need to be openly discussed, before being discounted, in order to prevent any miscarriage of justice.

(c) As an expert witness retained by the Crown, Dr Williams was under a duty to share the fact and arguable significance of the microbiology and biochemistry results and was wrong not to do so.

(d) By performing the post mortem examinations on Christopher and Harry, Dr Williams knowingly accepted the highest level of forensic paediatric responsibility and put himself in a position where he might have a pivotal role in a criminal trial.

(e) Dr Williams therefore had clear obligations from the outset to follow the stringent Home Office Recommendations and Guidelines, 1996 and had to be judged, not as a general pathologist, but as a competent forensic pathologist undertaking complex paediatric cases of this nature.

(f) Dr Williams's errors and omissions were formidable. Taken collectively as the setting in which his misconduct had to be assessed, the FPP was sure that his errors and omissions seriously undermined confidence in the role of a doctor as an expert witness.

(g) Dr Williams was either working beyond his competence (which is specifically condemned in *Good Medical Practice*) or was culpably careless, or both.

The Court of Criminal Appeal's findings

3. The judgment of the Court of Criminal Appeal was before the FPP. The Court found that Dr Williams had not acted in bad faith.

Sanction

4. After considering each of the options available to it and taking into account several sources of mitigation, the FPP determined to impose conditional registration upon Dr Williams to, in effect, ban him from all forms of forensic pathology by preventing him from undertaking any Home Office pathology or Coroner's cases for three years (the maximum period allowable).

5. The FPP also ordered that Dr Williams return to the FPP before the end of the three year period for further consideration as to whether the condition should be continued (by way of a resumed hearing).

Public Protection

6. The Council considered that the condition imposed by the FPP was broadly clear. Dr Williams is prevented from carrying out post mortem work. Dr Williams is also prevented from appearing as an expert witness instructed by the Crown, as this is within Home Office pathology. However, the precise effect of the FPP's sanction in relation to certain matters was not clear. It was unclear to the Council whether there might be overlap between some of the clinical activities carried out by Dr Williams as a consultant histopathologist and as a forensic pathologist. It was also not clear whether Dr Williams might still supervise others carrying out post mortem work or

clinical tasks, such as preparing sections and slides. Matters such as these might have been addressed by the FPP.

7. The FPP did not adequately address whether or not, given its findings about Dr Williams's clinical competence, he ought to be required for public protection to undertake any training or be subject to any auditing or supervision during his period of conditional registration.

8. Given the Council's concerns and the concerns expressed by the FPP itself with respect to evidence of a lack of support and career structure in England and Wales for forensic pathologists by the Home Office, the NHS and the Universities, the Council authorised officers of CHRE to enquire on its behalf of the GMC and/or of other appropriate bodies such as the Royal College of Pathologists as to the existence of any programmes for training which might be available to consultant histopathologists and/or forensic pathologists and the auditing and/or supervision of the work of consultant histopathologists and/or forensic pathologists. Further learning points discussed by the Council are documented separately and will be raised with the GMC in accordance with the section 29 Process and Guidelines.

Conclusion

The Council concluded that:

1. It had jurisdiction under section 29 of the Act to consider whether or not to refer this case to the High Court.

2. Based on the matters noted by the Council above, it considered it reasonable of the FPP to have found Dr Williams guilty of SPM and to have imposed the condition described in paragraph 4 above (with an order for a resumed hearing). Although the Council considered the sanction imposed on Dr Williams to be at the lenient end of the scale, given the FPP's findings, including the FPP's view that Dr Williams' errors and omissions were "formidable", in all the circumstances the conditions placed on his registration were not unduly lenient and it was not necessary for the protection of members of the public for CHRE to refer the matter to the High Court.

3. The Council considered that the criteria in section 29 of the Act had not been fulfilled. Accordingly there was no basis on which to exercise CHRE's discretion to refer the matter to the High Court.

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Jonathan Asbridge(Chair) Date: