Neutral Citation Number: [2016] EWHC 2739 (Admin)

Case No: CO/2061/2016

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

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 03/11/2016

Before :

MR JUSTICE MITTING

- -

Between :

DR WANEY MARIAN VALERIE SQUIER	**Appellant**
- and -	
GENERAL MEDICAL COUNCIL	**Respondent**

- -
- -

SIR ROBERT FRANCIS QC AND MISS CLODAGH BRADLEY QC
(instructed by **RadcliffesLeBrasseur**) for the **Appellant**
MR TOM KARK QC AND MISS ALEXANDRA FELIX
(instructed by **The General Medical Council**) for the **Respondent**

Hearing dates: 17, 18, 19, 20 & 21 October 2016

- -

Approved Judgment

MR JUSTICE MITTING :

Procedural history and background

1. Dr. Waney Marian Valerie Squier has been a consultant paediatric neuropathologist at the Oxford University John Radcliffe Hospitals since 1984. She is currently suspended as a result of the proceedings which are the subject of this appeal. She was awarded a BSc in anatomy in 1969 and an MBChB in 1972. She became a member of the Royal College of Physicians in paediatrics in 1974 and of the Royal College of Pathologists in histopathology in 1981. She became a fellow of the Royal College of Pathologists in 1992 and of the Royal College of Physicians in 2003. She practised as a registrar in neuropathology in 1975 and was appointed senior registrar in paediatric pathology at Great Ormond Street Hospital in 1978, where she worked until taking up her post as consultant at the John Radcliffe Hospitals in 1984. The core of her "ordinary" practice as a neuropathologist was the analysis of samples of brain tissue taken from both the living and the dead. No criticism is, or as far as I know, has ever been made about the conduct of her "ordinary" practice.

2. Since the start of her appointment she has conducted post-mortem examinations and provided reports to H M Coroner for Oxfordshire. Since the late 1980s, she has developed a medico-legal practice, providing reports as an expert neuropathologist to solicitors and giving evidence in cases in the civil, family and criminal courts. A significant and growing part of her medico-legal practice concerned cases of babies who had died as a result of suspected non-accidental head injury (NAHI). When she began to undertake this work, the opinion of the great majority of those who practised in fields relevant to it – neurosurgeons, radiologists, ophthamologists/ophthalmic pathologists, neuropathologists and forensic pathologists – was that, even in the absence of any sign of other injury, the coincidence of a triad of conditions, subdural haemorrhage, retinal haemorrhage and encephalopathy, was at least strongly indicative NAHI. Dr. Squier initially shared the majority view but, by about 2002, came to doubt it. Majority opinion has remained essentially the same. She, as she has always acknowledged, is in the minority. This case concerns reports which she has provided and evidence which she has given between 2007 and 2010 in the case six babies, of whom five died soon after allegedly sustaining NAHI.

3. On 1 April 2010 a complaint about Dr. Squier was made to the General Medical Council by the National Policing Improvement Agency. On 14 August 2014 a Notice of Hearing before the Fitness to Practise Panel was given by the GMC to Dr. Squier. Following a preliminary hearing on 15 – 26 September 2014, the FTPP gave directions for the substantive hearing. They were successfully challenged by judicial review proceedings before Ouseley J in January and February 2015. Following a judgment given on 13 February 2015, on 23 February 2015 he ordered that the Notice of Hearing of 14 August 2015 be quashed and that the GMC should serve a revised notice, which set out, with adequate particulars, the disciplinary charges of which Dr. Squier was accused. This was done. The substantive hearing took place between 5 October 2015 and 21 March 2016. On 11 March 2016, the Medical Practitioners' Tribunal, the statutory successor to the FTPP, handed down its written findings on the charges. On 17 March 2016, the MPT determined that Dr. Squier's fitness to practise was impaired. On 21 March 2016, it decided to direct that her name be erased from the medical register. She appeals against that decision under s40(1)(a) of the Medical Act 1983.

4. The parties have agreed that I should review the factual findings of the MPT and that if I conclude that they cannot, to a significant extent, be sustained, I should defer consideration of the MPT's decision on impairment and sanction until after they have had the opportunity to consider my judgment on the appeal on the factual issues. This is my judgment on those issues.

Law

5. The approach which I must adopt to the appeal is governed by CPR 52.11(3): I must allow an appeal where the decision of the MPT was wrong or unjust because of a serious procedural or other irregularity. To the extent that it is necessary to do so, I will address the case law on specific topics when I consider them.

Heads of charge

6. The heads of charge followed a pattern. Each group of charges related to one of the six babies about whom Dr. Squier had provided reports and given evidence. In each case, two or three basic factual allegations were made:

   i) Dr. Squier had expressed an opinion in a field outwith her expertise,

   ii) She made assertions in support of that opinion which were insufficiently founded on the evidence available to her,

   iii) She purported to rely on research papers which did not support her opinion in the way suggested by her.

   In the case of each factual allegation, further allegations were made (which are set out here and not repeated in the text of the charges set out below):

   i) She failed to discharge her duties as an expert by

      (a) failing to work within the limits of her competence,

      (b) failing to be objective and unbiased,

      (c) failing to pay due regard to the views of other experts,

   ii) Her acts and omissions were

      (a) misleading,

      (b) irresponsible,

      (c) deliberately misleading,

      (d) dishonest,

      (e) likely to bring the reputation of the medical profession into disrepute.

   The heads of charge provided a clear and useable template of the questions which the MPT were required to answer. To the extent that Sir Robert Francis QC for Dr. Squier suggested that they had a tendency to produce a mechanistic answer, I do not

accept his suggestion. If the answers were mechanistic, that was not the result of a faulty scheme of charges.

7. During the course of the case, Mr. Kark QC for the GMC indicated that he would not be pursuing some of the charges. There is no complaint about the course he took. I will not refer in this judgment to the charges abandoned before the MPT.

Witnesses

8. The GMC called five witnesses whose evidence was relevant to the issues arising in this appeal. Three were pathologists: Dr. Richard Bonshek, an ophthalmic pathologist, Professor Rupert Anthony Risdon, a paediatric and forensic pathologist and Professor Colin Smith, a professor of neuropathology. One was a neuroradiologist: Dr. Neil Stoodley. One was a silk practising in the family courts: Julia Cheetham QC. The three pathologists and the radiologist supported the majority view about NAHI cases. Sir Robert Francis suggested that, on that account, they might have been biased against Dr. Squier. The MPT rejected that suggestion. It was entitled to do so. The principal witness on whom the GMC relied was Professor Smith. I have read his report and have been referred to parts of his oral evidence, including that in which the suggestion of possible bias was made. The MPT concluded that he had been scrupulously objective in his report and evidence. Not only is that a view to which they were entitled to come, it is one that I share.

9. The MPT expressed itself less favourably impressed by some of the live evidence called for Dr. Squier. Some of its conclusions about them are, as expressed, untenable. The most egregious example is their finding about the evidence of Michael Birnbaum QC:

> "The Tribunal considered that at times Mr Birnbaum appeared somewhat vague. It believed that he lacked some credibility."

He had given evidence about his dealings with Dr. Squier in two criminal cases and about his assessment of her as a person and a witness. He conceded that he had a poor memory – hence, no doubt, the MPT's comment that he appeared somewhat vague; but that cannot sensibly have affected his assessment of Dr. Squier as a person and a witness. The statement that he lacked some credibility is a statement that, in some respects, his evidence was not worthy of belief. There was no foundation for such a statement. Mr. Kark conceded that there was not. His suggestion was that it was an infelicitous choice of words. I accept that it was, but still do not understand what it was that the MPT was concluding about Mr Birnbaum's evidence. In the end, this erroneous finding does not matter. It is simply the first of a number of unsustainable findings of greater significance.

10. Of greater concern is the MPT's finding and reasoning about Dr. Squier's truthfulness. Having found that she was "dogmatic, inflexible and unreceptive to any other view" – an opinion which it was fully entitled to form – it made the following observations about her evidence,

> "Your determination to pursue your own opinion was such that it led you to make what the Tribunal considers to be an outrageous and untruthful assertion before it that you had gone

> to the operating theatre and, "asked the surgeon to try and damage the arachnoid; it is extremely difficult"".

It gave three further examples of her "evasiveness": saying in her written statement about the first of the six cases that she did not understand where a specific allegation about a research paper had come from; in the same case, she said that she did not see any mention of a "lucid interval" in her report, but when reminded of her oral evidence, said the she was confused, which the MPT concluded was "incredible"; she denied receiving "feedback" (i.e. a copy or summary of the judgment) in the Family Division proceedings in which she had given evidence, which the Tribunal found "difficult to believe". The MPT said that it was "not able to accept large tracts" of her evidence.

11. The proceedings before the MPT were a "judicial proceeding" as defined by s1(2) of the Perjury Act 1911. The MPT's first, and principal finding, about Dr. Squier's evidence was in effect that she had committed an offence of perjury. This finding was unjust because of a serious irregularity in the proceedings before it. In her examination-in-chief by Sir Robert, he asked Dr. Squier whether she was aware of any reference (in the literature) to damage to the arachnoid membrane. In the middle of a long answer, she said the following,

> "I think I told you that I go to the theatre sometimes and I have specifically done this and gone and asked the surgeon to try and damage the arachnoid; it is extremely difficult. It is really tough. It is very thin, very fine and very tough. They can pick it up with forceps and stretch and you cannot get through it unless you cut through it with scissors…"

Mr. Kark wished to question her about this answer and properly gave advance notice to Sir Robert and the legal assessor of his intention to do so. The MPT asked the legal assessor to assist. He advised that the question was potentially proper (which it was) but that the answer might provide information which could be used in any subsequent GMC or criminal proceedings. He dealt with that and the possibility that Dr. Squier might be permitted to obtain legal advice before deciding whether or not to answer in the following passage.

> "On the question of legal advice, of course, it is a matter for Dr. Squier. If you decide that the question should be asked, she should be warned that any answer might be used in those proceedings and she can choose to answer it or not answer it. If she chooses not to answer it because she feels it might prejudice her later, that is not a matter you can hold against her, so it may be you feel that the question of legal advice evaporates anyway because there is no consequence, as it were, but of course you would not have an answer but that it the way it is."

She was given that opportunity and declined to answer Mr. Kark's questions on the topic.

12. Although the MPT did not expressly endorse the legal assessor's advice, they did not say that they did not accept it and can be taken to have done so. She was, therefore, told unequivocally that if she chose not to answer the questions because "she feels it might prejudice her later" in relation to criminal or disciplinary proceedings, her choice could not be held against her and would have no consequence adverse to her. Having exercised that right, she was entitled to assume that she would not be found to have lied – committed an act of perjury – as a result of doing so. The MPT gave no advance warning that they might adopt this course. This was a serious irregularity. It produced an unjust conclusion on a critical question.

13. The three remaining examples of "evasiveness" were, at best, makeweight. As to the first, Dr. Squier had stated in her defence statement that she was not able to respond to an allegation that she had misused a 2005 research paper by Kirsty Arbogast because she could find no reference to it in her report or in her oral evidence (of which she had transcripts). In consequence, she said that she did not understand the charge and was unable to respond to it. In her evidence before the MPT, she readily admitted that she had referred, if not by name, to the Arbogast paper. This was defensive nitpicking. To categorise it as evasive was an overstatement.

14. The second arose out of an extended passage of proper and skilful cross-examination of Dr. Squier by Mr. Kark. It produced contradictory answers: that she was not sure where she suggested that the baby had had a lucid interval between the occurrence of damage and loss of consciousness, (by reference to her written report), but had given oral evidence about it in the family proceedings and at the criminal trial. Her explanation for the difference was that she was confused. Her answers read like an attempt to justify an opinion about lucid intervals which she realised was difficult to support. The MPT's finding that her explanation of confusion was "incredible" was justified if, by it, they meant that she was struggling to justify an unsustainable opinion. To that extent, her answers were evasive.

15. As to the third, the MPT found it difficult to believe that Dr. Squier had not received "feedback" following the cases in which she gave expert opinion. She said in cross-examination that she rarely got the judgments in civil cases and was unable to remember being sent, by parents who had represented themselves, a copy of the judgment in their case (the second of those considered by the MPT). The MPT was entitled to be sceptical about the first answer; but it was just as much an indication of a closed mind as of a witness attempting to mislead. In any event, it, like the second minor criticism, was insignificant in the context of the major, unjust finding. Mr. Kark does not suggest that without that, the three examples of "evasiveness" could, by themselves, justify a conclusion that Dr. Squier's evidence before the MPT was, in significant part, false.

16. It is trite law that on an appeal from a fact-finding Tribunal such as the MPT, an appeal court must ordinarily defer to the assessment of the credibility of critical witnesses by the Tribunal. This is one of the rare cases in which unqualified deference is not possible. I cannot address the MPT's findings about Dr. Squier's state of mind, in particular that she deliberately misled courts and did so dishonestly, on the basis that she is a proven liar. The MPT's unjust finding does not prevent or inhibit an assessment of their findings on the basic facts. They depend on objective evidence – the contents of Dr. Squier's reports and transcripts of the evidence which she has given in the courts. However, any assessment of the validity of the MPT's

findings as to her state of mind, in particular as to whether she deliberately misled courts and/or did so dishonestly, must be made without reference to the unjust finding. It must depend upon inferences to be drawn from primary facts alone.

Expertise

17. In paragraphs 63 to 72 of its determination the MPT accurately summarised the areas of medical practice in which Dr. Squier had acquired expertise by qualification, study and experience as a neuropathologist. There was in the end no real issue about the major topics: biomechanics, paediatric neurosurgery, neuroradiology and ophthalmology/ophthalmic pathology. Dr. Squier had acquired a working understanding of these specialisms, as had her colleagues in her own and other disciplines; but, as she often said in evidence in the original cases, she deferred to the views of colleagues who were expert in the relevant field. The thrust of the GMC's criticism of her was that, despite that, she went on to challenge their evidence when there was no basis upon which she properly could. A great deal of evidence was given before the MPT, principally by Professor Smith, about the limits of expertise of a neuropathologist and what she could properly say about other disciplines. With one qualification, the MPT were entitled to accept that evidence and act upon it. The qualification is that, when the triad fell to be considered, any specialist, with the possible exception of a forensic pathologist, who supported or doubted the triad as indicative of NAHI, would be bound to be expressing an opinion outside his specialism. There can be no proper criticism of a neuropathologist, neuroradiologist or ophthalmologist/ophthalmic pathologist for explaining why he supports or doubts the majority view and in doing so, expresses a view about symptoms or pathological findings outside his own discipline. It is neither improper nor professional misconduct for an expert in one specialism to do so. The boundary line between a proper explanation of support or doubt and trespassing impermissibly outside the expertise of the witness is imprecise and difficult to identify in any particular case. It would have been better if the MPT had acknowledged that difficulty; but, with that qualification, there is and can be no justified criticism of its conclusions about the limits of Dr. Squier's expertise.

The six cases

O and F

18. O and F were the siblings of an eight month old male baby (A) who was admitted to hospital at midnight on 29/30 May 2007. He was pronounced dead at 11.22 am on 30 May. Post-mortem examination revealed the triad. A local authority brought proceedings in the Family Division in respect of O and F. On 27 June 2008 Pauffley J found that A's mother was responsible for his death. In July 2009 she was prosecuted for an offence of homicide before HH Judge Pontius and a jury at the Central Criminal Court. At the request of the parents' solicitors, Dr. Squier prepared a report about baby A dated 9 June 2008 and gave evidence before Pauffley J. She prepared an addendum dated 11 October 2008 and gave evidence for the mother in the criminal proceedings. Her report and evidence gave rise to the first group of charges before the MPT.

The charges

19.

"On 24 June 2008 you gave evidence, orally and by submitting and implicitly adopting a report dated 9 June 2008, in the Family Division of the High Court (The Family Court). **Admitted and found proved** in your evidence:

a. You provided expert opinion evidence outside your field of expertise by:

i. presenting opinion evidence, based in the field of biomechanics, as to the likelihood that a low level fall could have caused the brain injury which baby 'A' suffered;

ii. presenting opinion evidence based in the fields of ophthalmic pathology and/or ophthalmology;

iii. giving an opinion based in the field of paediatric neurosurgery in relation to the likelihood of baby A having had a lucid interval between injury and death.

b. You made assertions in support of your opinion which were insufficiently founded upon the evidence available to you, in that you:

ii. asserted that there was a left-sided unilateral subdural haemorrhage despite the evidence contained in the reports of Dr. Poole (6.9.07, 24.1.08, 5.2.08, 10.4.08) and Dr. Saunders (8.11.07, 1.2.08) describing a bilateral subdural haemorrhage.

c. You provided expert opinion evidence in which you purported to rely upon research papers set out below, whereas in fact that research did not support your opinion in the way in which you suggested, namely that in the circumstances of this case an accidental low level fall as opposed to an inflicted injury could have caused the brain injury and/or the retinal haemorrhages:

i.Vinchon M et al (2005);

ii. Hoskote A et al (2002);

iii Greenes DS and Schutzman SA (1998);

iv. Christian CW et al (1999);

v. Duhaime (1987);

vi. Cory and Jones (2003).

d. You provided expert opinion evidence in which you purported to rely upon the research paper set out below whereas in fact that research did not support you opinion in the way in which you suggested, namely that the child may have had a lucid interval:

Arbogast KB et al (2005).

5. On 23 and 24 July 2009 you gave oral evidence at the Central Criminal Court having provided reports dated 9 June 2008, 11 October 2008 and 3 November 2008. During the course of your oral evidence you:

a. provided expert opinion evidence outside your field of expertise by presenting opinion evidence, based in the field of biomechanics, as to the likelihood that a low level fall could have caused the brain injury which baby 'A' suffered;

b. provided expert opinion evidence in which you purported to rely upon research papers set out below, whereas in fact that research did not support your opinion in the way in which you suggested namely that an accidental low level fall as opposed to an inflicted injury could have caused the brain injury and/or the retinal haemorrhages:

i. Christian CW et al (1999);

ii. Duhaime (1987);

iii. Cory and Jones (2003)."

The MPT's findings

2(a)(i)

20. In her report dated 9 June 2008 Dr. Squier expressed reservations about the observation by Mr. Richards, a neurosurgeon, in his report that the injuries suffered by A have been associated with injuries that originate with an excessive shake; and of his understanding of the forces which would result. Dr. Squier stated that a biomechanical opinion would be most helpful on those points. She referred to research papers which were the subject of separate sub-charges and strongly recommended that the opinion of an expert in biomechanics be sought. She then went on to deal with a possible hypothesis as to the cause of A's injuries – a low level fall, for which she cited research papers which were the subject of separate sub-charges. She referred to studies about the level of force required to cause injuries and reproduced a table based on research work with dummies to illustrate her point that low level falls could produce more force than those generated by shaking and

slamming a dummy on a bed or sofa. She said that she was not qualified to assess the significance of these studies but felt it was very important that a biomechanical expert be requested to comment. When considering shaking, she expressed the view that shaking alone could not achieve the forces required to cause intra-cranial bleeding and again cited papers that were the subject of separate sub-charges. Her opinion was that the findings at post-mortem were consistent with impact trauma occurring up to two days prior to death.

21. In her evidence to Pauffley J, Dr. Squier touched briefly on biomechanics. She was asked by the mother's counsel if the non-specific pathology which she discerned from the history (alone – she had not seen scans or photographs of the brain or brain tissue) was consistent with the mother's account, she said,

> "Well that is what I have said but in a way I depend on the evidence of the biomechanical studies to support this opinion because they can give us objective analysis of the forces which can be generated by falls such as that that is described by (the mother). If one can take what the biomechanical evidence tells us then it is possible to explain the brain findings on the basis of a short fall. On the basis of biomechanical evidence in cases I have seen I firmly believe that in rare cases it is possible for a fall of this type to generate sufficient force to cause this sort of brain damage."

Later on, in cross-examination by counsel for the local authority, she was asked whether she felt qualified to answer questions about the logistics of falls and different impact-type mechanisms. Her response was,

> "Much better addressed to Dr. Van Ee."

(The biomechanical expert whom she had suggested should be consulted).

22. In finding this sub-charge proved, the MPT noted, correctly, that Professor Smith and Dr. Van Ee said that the opinions which Dr. Squier expressed, summarised above, were within the field of biomechanics. It went on to find that after Dr. Van Ee had provided an opinion she "still provided evidence on this matter" even though it was outside her area of expertise.

23. The MPT was correct to conclude, as she readily conceded, that biomechanics was outside her field of expertise and also correct that in her report she had drawn attention to biomechanical studies which she said supported, as a possible cause of the fatal injuries, a low level fall. To that limited extent, its conclusion was justified. The MPT dealt with the further characterisation of Dr. Squier's conduct in relation to the three sub-charges in paragraph 2 compendiously; and I shall do the same.

2(a)(ii)

24. In her report of 9 June 2008, Dr. Squier did no more than summarise, in a few words, the findings of Professor Fielder and Dr. Bonshek, an ophthalmologist and ophthalmic pathologist respectively. She made no other comment about the eyes. In her evidence before Pauffley J she was cross-examined about their joint opinion and invited by

counsel for the local authority to express her opinion. In response, she pointed to research papers, but twice expressly disclaimed any expertise in retinal haemorrhage and expressly said that she would accept the opinion of Professor Fielder and Dr. Bonshek and would "obviously" defer to them.

25. The MPT concluded that, in her report and evidence, she had strayed outside her expertise into ophthalmology or ophthalmic pathology. The conclusion was mistaken as to the report and unfair as to her oral evidence. It is possible that the mistake arose because Dr. Squier did comment on the report of Dr. Bonshek in an addendum, prepared for the purpose of the criminal proceedings, dated 3 November 2008 – a report which was not available at the time of the family proceedings. In it, too, she disclaimed any expertise in "the multiple aetiologies of retinal haemorrhage". The MPT's conclusion about her evidence was unfair, because she only said anything about retinal haemorrhages because pressed to do so by cross-examination by counsel for the local authority. In the course of doing so she twice stated that she was not an expert in retinal haemorrhages and once expressly accepted the evidence of Professor Fielder and Dr. Bonshek and said that she would "obviously" defer to them. Save in a literal sense this sub-charge was not made out.

2(a)(iii)

26. Dr. Squier made no mention of a lucid interval in her report of 9 June 2008. She was asked about it in-chief by counsel for the mother, who asked her about the evidence of other experts that the trauma to the brain must have immediately preceded collapse. She gave a lengthy answer, preceded by the statement, "I am not a clinician". In cross-examination by counsel for the local authority, it was put to her that the opinion of Mr. Richards, a paediatric neurosurgeon, should be preferred on this topic to any view that she might hold. Her response was that "of course" she should defer to his opinion.

27. The MPT accepted Professor Smith's view that the existence or non-existence of a lucid interval in any particular case was a matter for clinicians, not a neuropathologist. It was entitled to do so. However, as in the case of sub-charge 2(a)(ii), this sub-charge was made out only in a literal sense.

2(b)(ii)

28. In her report of 9 June 2008 Dr. Squier noted that in the statement of Dr. Saunders, a consultant paediatric neuroradiologist dated 8 November 2007, she had examined a post-mortem MRI scan which showed <u>bilateral</u> subdural haemorrhage and sub-arachnoid blood. She also noted the statement of Dr. Jeanes, a consultant paediatric radiologist, who had examined a CT scan taken on admission while baby A was still alive and correctly stated that she had seen a <u>left</u> subdural haemorrhage. She made no further comment about this apparent difference in her report. The report contained no mention of a short further statement by Dr. Saunders made on 1 February 2008, in which she said that she had now looked at the CT scan examined by Dr. Jeanes and was "able to say that my conclusions have not been altered in any way". Dr. Squier accepted that she had seen this addendum when she gave her oral evidence, but not when she prepared her report. In her oral evidence she was asked by counsel for the mother about the apparent difference between the CT scan and the MRI scan and said that in her opinion it may have been due to further bleeding occurring between them:

what was seen post-mortem was not necessarily an accurate reflection of what happened at the time of injury. Counsel for the local authority began her cross-examination of Dr. Squier by stating that there appeared to be "some discrepancy at the moment as to whether or not in fact that CT scan showed a subdural bleed on just the left or a bilateral bleed". When asked whether a CT scan could be less sensitive than a subsequent MRI scan, she replied that she would have to ask a radiologist.

29. In paragraph 102 of its determination, the Tribunal made a strong finding about this difference,

> "The Tribunal has determined that…there was no evidence of a asymmetric or bilateral bleed on CT scan at the time you wrote your report dated 9 June 2008 or when you gave your evidence in the family court on 24 June 2008, it was clear from Dr. Saunders' reports dated 8 November 2007 and 1 February 2008 that the CT scan had shown a bilateral subdural haemorrhage."

30. With respect to the Tribunal, this finding was factually wrong. Dr. Jeanes' statement provided clear evidence of a unilateral subdural haemorrhage. She said as much, "the appearances were of an acute left-sided subdural haemorrhage." She said that she had discussed the case with a colleague, Dr. John Rendle and a consultant neuroradiologist, Dr. John Stevens. In statements made on 23 August 2007 and 31 May 2007 respectively, Dr. Simon Nadel, a consultant paediatrician and Dr. Mehrengise Cooper, a consultant intensive care paediatrician noted that the CT scan showed left-sided subdural bleeding. Three contemporaneous clinical notes by a specialist registrar, by or for a consultant intensive care paediatrician and by Dr. Jeanes' senior house officer recorded the same.

31. The MPT went on to conclude that Dr. Jeanes' report "allowed you to build a scenario that the brain injury was caused by a fall…" and that she should not have ignored the opinion of Dr. Saunders. It also concluded, without an evidential basis for doing so, that Dr. Saunders' addendum of 1 February 2008 "had been available" to her. In her reports, Dr. Squier was meticulous in noting the documents which she had read. There was no reason for her to have departed from her normal practice in this instance. The MPT also criticised what Dr. Squier said had been a typing error in her report when she referred to "scans" in the plural, when there was only one CT scan. Again, the MPT had no basis, other than its rejection of large tracts of her evidence, for dismissing her explanation that this was a typing error.

32. By the time that the issue was determined (in favour of Dr. Saunders' interpretation) by Pauffley J, Dr. Saunders had had the opportunity to look again at the CT scan and confirmed that it showed bilateral, albeit asymmetric bleeding. Dr. Jeanes did so as well, and did not, in the end, disagree with Dr. Saunders. As, however, was made clear to Dr. Squier when she was being cross-examined by counsel for the local authority, none of this was clear when she gave her evidence. When she did, there was evidence of a left-sided unilateral subdural haemorrhage provided by a relevant specialist, Dr. Jeanes, which was not obviously wrong. This sub-charge was not made out.

2(c)

33. Each sub-allegation in this paragraph concerned an identified research paper. The over-arching theme was that Dr. Squier had, in her report of 9 June 2008 and in her evidence cited research reports in support of her hypothesis that the brain injury which caused death was consistent with a low level fall, which might have been accidental, rather than deliberate shaking. I have paraphrased the charge, because that is what, in essence, was being alleged.

34. The duties of an expert when citing the work of others are not controversial. The nature of the duty can be discerned from the following statements of principle.

i) In *Re: AB (Child abuse: expert witness)* [1995] 1FLR 181 Wall J observed that when there was a genuine disagreement on a scientific or medical issue or where it was necessary for one party to advance a particular hypothesis, an expert is under the following duty:

> "…the expert who advances such a hypothesis owes a very heavy duty to explain to the court that what he is advancing is a hypothesis, that it is controversial (if it is) and to place before the court all the material which contradicts the hypothesis. Secondly, he must make all his material available to the other experts in the case."

ii) Paragraph 10 of the GMC Guidance on Acting as an Expert Witness issued in July 2008 (withdrawn 22 April 2013):

> "10. You must make sure that any report you write or evidence you give is accurate and is not misleading. This means that you must take reasonable steps to verify any information you provide, and you must not deliberately leave out relevant information."

iii) Guidance for the Instruction of Experts to Give Evidence in Civil Claims 2014.

> "13. Experts should take into all material facts before them. Their report should set out those facts and literature or material on which they have relied informing their opinions."

iv) Criminal Procedure Rules 2015.

> "19.4…An expert's report must –
>
> b) give details of any literature or other information which the expert has relied on in making the report."

Although (iii) and (iv) post-date the evidence given by Dr. Squier, they state principles which have not changed since she did. It is axiomatic, and does not need to be spelt out in a rule, that an expert must not cite the work of others as supporting her view when it does not. If it is capable of doing so, but only with significant qualification, she must say so. Sir Robert Francis submitted that, in a field such as

NAHI in babies, the number of those able to give relevant evidence is small and those who are willing to do so smaller, so that all that it is necessary for an expert to do is to cite the research paper by name and date and leave it to others to point out the respects in which the paper does not support her view. I do not accept that proposition. One of the overriding duties of an expert is not to mislead. Baldly stating, without qualification, that a research paper is a proper foundation for the proposition that the expert is seeking to advance is justified if that is the conclusion of the research paper; but if it is not, it should not be cited, without qualification, as supportive. From a detailed analysis of Dr. Squier's practice in relation to research papers which were the subject of charges, it seems that she often cited a research paper, not for its conclusion which did not support her opinion, but for some nugget within it which might do. When she did that, she was not fulfilling her duty as an expert witness. As will be seen when I look at the individual research papers allegedly mis-cited, there are occasions when questions of degree arise. I will deal with them and the MPT's approach to them under relevant sub-charges.

2(c)(i), 2(c)(ii), 2(c)(iii) and 2(c)(iv)

35. In her report of 9 June 2008, Dr. Squier stated

> "Serious head injury from short falls is very unusual. However, there are published reports showing that low level falls <u>can</u> cause serious intracranial injury and this mechanism of injury cannot be dismissed out of hand (Vinchon 2005, Hoskote 2002, Greenes and Schutzman 1998) Vinchon describes 55 infants hospitalised with severe intracranial injury after household falls (including 13 from a seat, 9 from the arms of an adult, 9 from a table, 2 from a bed). In Hoskote's paper two infants suffered SDH after short falls, one from a father's arms and one from a bed. Greenes and Schutzman describe 14 babies, all 8 months or less in age, with asymptomatic intracranial haemorrhage after falls down 9 stairs or less.)
>
> Falls even from low levels of less than 3 feet can generate far greater forces to the head than impulsive action (or shaking) (Van Ee personal communication 2007 (see below), Prange 2003). Ipsilateral subdural hemorrhage and retinal hemorrhage has been described in accidental household falls (Christian 1999).
>
> Thus the literature supports the view that a low level fall could have caused the fall in this case."

36. Dr. Squier's report did not misstate the facts which she sought to extract from the four research papers; but her citation was so selective as to misrepresent each of them.

37. The abstract of the 2005 research paper headed Accidental and Non-Accidental Head Injuries in Infants written by a multi-disciplinary team led by Mattthieu Vinchon, a paediatric neurosurgeon, stated,

> "Subdural haematomas were significantly correlated with RH (retinal haemorrhage) and with child abuse but not with idiopathic macrocranium. The sensitivity and specificity of RH for the diagnosis of child abuse were 75 and 93.2% respectively. Retinal haemorrhages associated with accidental trauma were always mild, and the specificity of more severe RH for the diagnosis of child abuse was 100%."

38. In their conclusions, the authors of the Hoskote paper, all of whom were colleagues of Dr. Squier at John Radcliffe Hospital stated, amongst their conclusions,

> "2. In the group that were unexplained on initial presentation (n = 23), 14 were due to NAHI. The useful predictors for NAHI were aged less than 16 weeks, inconsistent history, presence of retinal haemorrhages positive skeletal survey and unexplained bruising."

39. Greenes and Schutzman found that 19 infants younger than 12 months of age admitted with head trauma (18 had fractures on skull radiographs) were clinically occult (i.e. there was no external sign of injury). None of them suffered serious neurological deterioration or required surgical intervention. All of them lived. Neither of the expert witnesses upon whom the MPT relied (Dr. Stoodley (a neuroradiologist) and Professor Smith (a neuropathologist)) thought that the findings in this paper were of any relevance to the hypothesis advanced by Dr. Squier – that baby A's fatal injuries were consistent with a low level fall.

40. The 1999 paper by Dr. Cindy W Christian and colleagues identified three children with unilateral retinal haemorrhages caused by accidental household trauma. Two of them did not suffer low level falls (one fell down 13 concrete basement stairs and one fell through a stair rail on to a concrete basement floor). The third fell one to two feet while being swung in play by his father. All of them lived. The MPT accepted the evidence of Dr. Bonshek (an ophthalmic pathologist) and Professor Smith that they had no relevance to the hypothesis advanced by Dr. Squier.

41. In each case, Dr. Squier was guilty of misstatement by omission; in the case of the Vinchon paper, by omitting the authors' clear conclusion about the coincidence of abusive injury and retinal haemorrhage in small babies; in the case of the Hoskote paper, by omitting their conclusion about the useful predictors for NAHI, including retinal haemorrhage; in the case of the Greenes and Schutzman paper, by omitting reference to the benign outcomes; and in the case of the Christian paper, by omitting reference to the height of fall in two out of three cases and the benign outcome in all. The MPT reached its conclusions largely on the basis of the expert evidence which it heard, which assisted its understanding of the papers. Their thrust was, in any event, clear. The MPT's findings were justified.

2(c)(v) and 2(c)(vi)

42. In her report of 9 June 2008 Dr. Squier stated,

> "As far as scientific analysis is concerned there have been a number of reproducible studies which have consistently shown

> that shaking alone cannot generate forces considered sufficient to cause brain injury (Ommaya 2002, Duhaime 1987, Cory and Jones 2003, Prange 2003)."

Comments to similar effect were made later on in the report. The MPT concluded, on the basis of evidence given to it by Dr. Van Ee, a biomechanical expert, that Dr. Squier had "completely misinterpreted" what Duhaime had actually said and was incorrect in her summary of Cory and Jones, in each case for the same reason: she said that the studies showed that shaking alone "cannot" generate sufficient forces to cause brain injury. They did not say that. The conclusion of the Duhaime paper was that "the shaken baby syndrome, at least in its most severe acute form, is not usually caused by shaking alone. Although shaking may, in fact, be a part of the process, it is more likely that such infants suffer a blunt impact." Cory and Jones concluded that at the present stage "it cannot be categorically stated, from a biomechanical perspective, that pure shaking cannot cause fatal head injuries in an infant".

43. The MPT were right to conclude that the two papers did not support the precise words used by Dr. Squier to describe them; but Duhaime came close to doing so. Cory and Jones qualified Duhaime's conclusions and expressed a further conclusion of their own – that there must be sufficient doubt of the reliability of the Duhaime study to warrant the exclusion of such testimony in cases of shaken baby syndrome. The latter conclusion was not (or perhaps should not have been) the conclusion of the biomechanical expert C Z Cory but of his co-author, M D Jones, a barrister. The MPT did not rely on this statement within the Cory and Jones paper and were right not to do so. The nub of their justified conclusion was that Dr. Squier had overstated the conclusions which a biomechanical expert would draw from papers. This was a good example of her giving evidence outside her expertise, but, properly stated, both reports were not inconsistent with, and were to an extent supportive of, her hypothesis that a fall from a low height could cause fatal head injuries in small babies. The sub-charges as worded were not, therefore, made out. These were not examples of deliberate mis-citation of research papers.

2(d)

44. As already noted, Dr. Squier made no reference to lucid intervals in her report; but she did say in oral evidence that a study done in 2005 (the Arbogast paper) showed that infants under the age of two were far more likely to express a lucid interval than older children. She was not cross-examined about this statement.

45. The Arbogast paper did conclude that on a rare occasion an infant or toddler could sustain a fatal head injury yet present as lucid to hospital clinicians before death. However, the authors also said that they were unable to determine whether that was because of differences in pathological injury, neurological responses unique to the infant brain, or limitations of the bedside methods used to assess neurological function in young children.

46. The MPT determined that to state the conclusion without the qualifications misrepresented the paper. Their finding was justified.

Consequential findings

3(a)

47. The MPT found that Dr. Squier had provided evidence in the fields identified in sub-charge 2(a) and so acted outside her area of expertise. To the limited extent already stated, this finding was justified. So too, and to the same extent, were the findings in relation to sub-charges 2(c)(v) – (vi).

3(b)

48. The MPT cited a long passage from Professor Smith's evidence to the effect that he was surprised that Dr. Squier had not offered differential diagnoses in this case. Although the MPT did not expressly say so, they clearly accepted this evidence and added it to their finding that Dr. Squier had given evidence outside her expertise. They concluded that her report and oral evidence were not objective and unbiased. Although, as stated above, the latter conclusion was only justified to a limited extent, the overall conclusion was one which the MPT were entitled to reach. I would have added to Professor Smith's conclusion the mis-citation of the research papers identified above and by that route reached the same conclusion as the MPT. This finding was justified.

3(c)

49. The MPT found that Dr. Squier had failed to pay due regard to the views of Mr. Richards, Dr. Saunders and Dr. Bonshek. For the reasons explained above, this finding was not justified.

4(a)

50. The MPT found that Dr. Squier's actions and omissions were misleading in four respects:

    i) Evidence given outside her expertise would mislead anyone who received it who would take it to be within her expertise.

    ii) Her evidence about the left-sided subdural haemorrhage was misleading.

    iii) Her evidence about lucid intervals was misleading, because it was contrary to the opinion of Mr. Richards.

    iv) She cited research papers which did not support her "clinical opinion".

    For reasons explained above, the first three were not made out. With the modification that she did not express a "clinical opinion", the fourth was.

4(b)

51. For the same four reasons, the MPT concluded that Dr. Squier's actions and omissions were irresponsible. For the same reasons, the first three conclusions were not justified, but the fourth was.

4(c)

52. The MPT found that Dr. Squier's actions and omissions were deliberately misleading, for three reasons;

    i) Giving evidence outside her expertise must have been deliberate.

    ii) Giving evidence about a left-sided subdural haemorrhage must have been deliberate.

    iii) "You told the Tribunal that you understood the research literature. Your misuse of the literature by cherry-picking elements to support your opinion and choosing to use literature outside your field of expertise can only have been deliberately misleading".

53. For the reasons already explained, the first two findings were not justified, the third was. At the end of a long and penetrating cross-examination by Mr Kark, Dr. Squier stated firmly that she understood the research very well and used the literature to the best of her ability as would a scientist to support a proposition that she was making. She did cherry-pick the Vinchon, Hoskote, Greenes and Schutzman, Christian and Arbogast papers. Given that she understood these papers well, she must have known that she was not citing them fairly or accurately. Her mis-citation can only have been deliberate. In that respect her actions and omissions were deliberately misleading. They were not in relation to the other research papers. Nor was the fact that she cited papers outside her expertise. For the reasons already explained, she cannot sensibly be taken to have intended to mislead when commenting on disciplines about which she expressly disclaimed expertise and deferred to others.

4(d)

54. The MPT applied a modified *Ghosh* [1982] QB 1053 test and concluded that her acts and omissions were dishonest by the standard of honest and reasonable doctors and that she must have realised they were. It found that she had been dishonest in two respects,

    i) In asserting that there had been a left-sided subdural haemorrhage;

    ii) In mis-citing the research literature.

    For reasons already explained, the first was not justified. The second added nothing to the finding of cherry-picking the five identified papers. Mr Kark has explained the reasons for the presence of charges of dishonesty: if a suggestion of dishonesty is made, it must be expressly charged. Nevertheless, in a case such as this, where the real charge is that the registrant has repeatedly breached the duties of an expert witness and in doing so attempted to mislead the Tribunal before whom she was giving evidence, a finding of dishonesty could only add anything material to the outcome if the evidence was given for an ulterior purpose – for example, to make a living. There has never been any suggestion that Dr. Squier had an ulterior purpose. It has always been accepted that her views were genuinely held. What is in issue is the manner in which she has advanced them. A Tribunal is under no obligation to make an unnecessary finding. The MPT should have made no finding about

dishonesty in this case. For that reason, it should not have found sub-charge 4(d) proved. Nor should it have made any finding of dishonesty in relation to any other sub-charge. I do not propose to repeat this in relation to any other sub-charge.

4(e)

55. The MPT found that, because courts and tribunals rely on honest medical expert witnesses, the giving of misleading and dishonest evidence inevitably brought the reputation of the medical profession into disrepute. For the same reasons as those given in relation to the charge of dishonesty, it was not necessary for the Tribunal to make a finding on this sub-charge and it should not have done so. The same reasoning applies to all similar sub-charges.

5(a)

56. The MPT dealt with this sub-charge briefly. It stated, correctly, that Dr. Squier had referred to the Duhaime and Cory and Jones papers in her evidence. It stated, again correctly, that, when asked by counsel for the mother to deal with her "experience of experimentation" she went on to give extensive evidence about the biomechanical studies. Her first answer took up two pages of transcript. They were the beginning of her justification for not rejecting the mother's account as a potential explanation for baby A's injuries. It is true that, later in her evidence when she stated that a short fall was capable of generating the forces which could cause his injuries, she said that it was not her area of expertise; but it is, by then, not unlikely that the damage had already been done. She was giving evidence before a judge and jury. The jury could not have been expected to have had any prior understanding of the mechanism by which NAHI in babies could be caused. Dr. Squier was giving evidence in support of her proposition that the most likely explanation was a short fall onto a carpeted floor. Her examination-in-chief concluded with the sentence, "that would appear to be the most likely explanation." There was at least a significant risk, more likely a high probability, that any juror listening to her would treat her evidence about biomechanics as expert evidence. It was not. Her subsequent disclaimer, in cross-examination, of expertise, on two occasions (transcript internal page 33H and 55F), may well not have dispelled the impression given earlier, that she knew what she was talking about, as an expert. The MPT were right to find this sub-charge proved.

5(b)(i)

57. Dr. Squier was cross-examined about the Christian paper. Its conclusions were fully stated in lengthy questions by counsel for the Crown. Towards the end of her cross-examination on this paper, she said,

> "These are three accidental household falls and the interesting point about these is that the retinal haemorrhage and the subdural haemorrhage were on the same side."

That was an accurate statement of part of the description in the paper.

58. The MPT cited an extensive passage of evidence from Professor Smith which was critical of that answer, principally because it did not draw attention to the difference in the retinal haemorrhages in the three infants and because they did not die. Relying

on that evidence, the MPT concluded that Dr. Squier mis-cited the Christian paper to support her hypothesis a low level fall.

59. The MPT's conclusion was unfair and should have not have been reached. In *Meadow v General Medical Council* [2007] QB 462 Auld LJ gave wise advice to tribunals assessing the conduct of a medical expert witness at paragraphs 205 to 207.

> "205. Where the conduct of an expert alleged to amount to a professional offence under scrutiny by his professional disciplinary body arises out of evidence that he has given to a court or other tribunal, it is, therefore, important that that body should fully understand and assess his conduct in the forensic context in which it arose. Of great importance are the circumstances in which he came to give the evidence, the way in which he gave it, and the potential effect, if any, it had on the proceedings and their outcome. If the disciplinary body lacks information to enable it properly to assess the expert's conduct in that forensic context, or fails properly to take it into account, a court reviewing its determination, is likely to bring important insights of its own into the matter. Not least amongst those should be an appreciation of the isolation of an expert witness, however seasoned in that role in the alien confines of the witness box in an adversarial contest over which the judge and the lawyers hold the sway."

In paragraphs 206 to 207 Auld LJ went on to set out the stresses and strains which inevitably arose in litigation,

> "In that, sometimes, fevered process, mistakes can be made, ill-considered assertions volunteered or analogies drawn by the most seasoned court performers, whatever their role."

60. Given the circumstances in which Dr. Squier gave the impugned answer the MPT's finding that she mis-cited the Christian paper in the criminal trial cannot stand.

5(b)(ii) &(iii)

61. Dr. Squier mentioned Duhaime for the first time in cross-examination.

> "Q….Do you say that you draw from Duhaime the conclusion that studies and this study, shows that shaking alone cannot generate forces sufficient to cause brain injury?
>
> A. Yes."

She went on to explain that Duhaime's experiments did not generate forces sufficient to cause concussion, subdural haemorrhage or axonal injury. She was then referred to Cory and Jones and gave a lengthy answer which concluded,

> "So, again, their results have not shown that, even with their model and all of their caution, that they have managed to get

> forces which are thought to be sufficient to cause even subdural haemorrhage, let alone axonal injury."

62. The MPT concluded that Dr. Squier had mis-cited both papers in support of her proposition that baby A's injuries could have been caused by a low fall. She did not. All that she did was to agree with the question put to her by counsel for the Crown that she had drawn the conclusion from Duhaime that shaking alone could not generate forces considered sufficient to cause brain injury. Her answer was correct. She did not mis-cite the Cory and Jones paper and gave a full explanation of what she drew from it. The evidence was outwith her expertise, but it did not mis-cite either paper. Both of the MPT's findings are wrong.

Consequential findings

6 and 7

63. All that it is necessary to state is that the MPT's conclusions that Dr. Squier failed to work within the limits of her competence or to be objective or unbiased and was irresponsible were justified in relation to sub-charge 5(a), but not otherwise. It was wrong to uphold the remainder of sub-charges 6 and 7.

F and L

64. Y is the step-brother of A. On 30 March 1999, aged about two months, he was admitted to hospital with what transpired to be a serious brain injury resulting in cerebral palsy. In care proceedings, Y's brain damage was found to have been the result of a NAHI. Y's father remarried. A daughter, A, was born to him and his new wife. She was the subject of emergency proceedings brought by the local authority, at the end of which an application was made for her placement for adoption. The father challenged the application. In the course of those proceedings, on 30 January 2009 Hedley J determined that on the balance of probabilities, Y did suffer NAHI while in the custody of his parents. At the request of the father, Dr. Squier prepared a report dated 30 May 2008. The court directed that the local authority should seek clarification of Dr. Squier's report from her. She responded with a fuller report dated 17 September 2008 and with a commentary on the reports of other experts dated 10 January 2009. On 14 January 2009, she gave evidence before Hedley J. There is a (very) imperfect transcript of her evidence.

The charges

65.

> "Case of: F & L
>
> 8. Between 2008 and 2009 you acted as an expert witness in the case of F and L (A Local Authority and Another and F and L) which involved brain damage to baby 'Y' (at the age of one month) in the Family Division of the High Court (The Family Court). **Admitted and found proved**

> 9. On 14 January 2009 you gave evidence, orally and by submitting and implicitly adopting reports dated 30 May 2008, 17 September 2008 and 10 January 2009, in the Family Court. **Admitted and found proved**
>
> In your evidence:
>
> a. You provided expert opinion evidence outside your field of expertise by:
>
> (i) giving evidence based in the field of paediatric medicine;
>
> (ii) giving evidence based in the field of neuropathology;
>
> (iii) giving expert evidence in relation to the clinical presentation and radiological findings based solely on the clinical notes and an assessment of clinical and neuroradiological data there being no pathological material for you to assess.
>
> b. You provided expert opinion evidence in which you purported to rely upon the research paper set out below whereas in fact that research did not support your opinion in the way in which you suggested namely that there was no asymptomatic birth related subdural bleeding leading to chronic subdural membrane with rebleeding;
>
> Rooks VJ et al (2008)."

Sub-charges 10 and 11 repeated the categorization of her conduct in words identical to those used in the case of O and F.

<u>The MPT's findings</u>

9(a)(i)

66. The MPT found that in her evidence to Hedley J, Dr. Squier stated,

> "now the brain will start swelling in response to injury within I think about 20 minutes is the generally accepted time, and the maximum swelling is 24 – 30 hours, and this is certainly borne out of my own experience looking at babies who have suffered injury at birth."

In consequence, it found that she had given evidence in the field of paediatric medicine, outside her expertise.

67. Dr. Squier did not give this evidence in this case. The passage cited is taken from the transcript of her evidence in the criminal case of *SC* (transcript internal page 184 4 - 7). The MPT's finding was wrong.

9(a)(ii)

68. The only material available to Dr. Squier when she prepared her reports were the case notes, scan reports, some correspondence and the reports of other experts. She initially observed that the case notes suggested that Y had suffered cerebral venous sinus thrombosis and strongly recommended that the brain scans be reviewed by a paediatric neuroradiologist. They were, by Dr. Stoodley, and her initial suggestion was shown to be erroneous. The scans and the report by Dr. Michael Nelson, a consultant radiologist, demonstrated that Y had suffered a subdural haematoma. Having herself reviewed the scan report, Dr. Squier stated that there was no evidence of shaking or impact. In the course of her review of the reports of other experts, she commented unfavourably on the report of Dr. Stoodley. In a passaged cited by the MPT she said,

> "He begins with an "EXPLANATION OF TERMS" which demonstrates a lack of understanding of some basic but highly relevant anatomy and pathology."

She explained why. She then went on to deal with the substance of Dr. Stoodley's report and to express views about radiology. From the redacted judgment of Hedley J available to the MPT, it is clear that she did give evidence in support of the opinions expressed in her report.

69. The MPT concluded that the tone of her report of 10 January 2009 was sarcastic and disparaging and completely dismissive of Dr. Stoodley's expert opinion. It accepted the evidence of Professor Smith and Dr. Stoodley that the thrust of the evidence which she gave was that the neuroradiological evidence must have been misinterpreted. In consequence, the MPT found that she had given evidence outside her expertise.

70. It was entitled to do so, though the fact that the tone of her report was found to be sarcastic and disparaging and that she stated that Dr. Stoodley's report demonstrated a lack of understanding in a field in which she was expert – anatomy and pathology – was not material to the finding.

9(a)(iii)

71. Dr. Squier did give evidence in relation to clinical presentation and radiological findings based solely on clinical notes and an assessment of clinical and neuroradiological data. So too, did the other experts. There was no way of approaching the case other than to do so. The real criticism is that she was giving evidence outside her expertise – a repetition of the previous sub-charge. The MPT were entitled to find this sub-charge proved, but it added nothing to 9(a)(ii).

9(b)

72. In her report of 17 September 2008, Dr. Squier stated that subdural bleeding occurs in up to 46% of asymptomatic babies following normal delivery and cited a 2008 paper by Rooks and others in support. In her supplementary comments, she stated,

> "Three radiological publications show that subdural haemorrhage is common following all forms of delivery including caesarean section (Rooks 2008, Looney 2007, Whitby (2004). In the most recent of these (Rooks 2008), 46% asymptomatic neo-nates had evidence of subdural bleeding. These authors followed up only 18 cases and for a maximum of three months. One of their 18 cases had subdural bleeding, which, if taken at face value, would indicate that the risk of later development of chronic SDH would be very significant."

She then went on to cite another paper,

> "In view of the very few babies followed up, these studies cannot be regarded as statistically significant observations in view of the fact that so many babies are born with subdural haemorrhage (almost 50% of the population) and so few followed up. There remains the possibility that birth related subdural haemorrhages may go on to become chronic subdural haemorrhages."

73. In his evidence to the MPT, Professor Smith said that Dr. Squier had described the Rooks paper accurately. His criticism was that it did not support the hypothesis which she was advancing – an asymptomatic birth related subdural bleed which goes on to form a chronic subdural membrane which rebleeds, causing sudden death. She did not mis-cite the Rooks paper in support of this hypothesis. All that she did was to express a cautious, tentative conclusion in the last sentence of the passage cited.

The MPT were, on the evidence which they heard and the material which they considered entitled to conclude as they did, there was no support in the Rooks paper for Dr. Squier's ultimate hypothesis. If that was all that this sub-charge meant their conclusion was justified; but they later went on to find that her actions and omissions in this respect were deliberately misleading. In other words, they treated the thrust of this sub-charge as an allegation that she had mis-cited the Rooks paper. She had not. Either the MPT were wrong to find that she had done so or they did no more than state the obvious – that it was insufficient, by itself, to support her hypothesis. The MPT should not have found this charge proved.

Consequential findings

10 and 11

74. The MPT were entitled to find sub-charges 10(a) and (b) and 11(b) proved in relation to sub-charge 9(a)(ii) but not otherwise and not in any other respect.

F, G and H

75. On 11 April 2007 an eight month old boy (A) was admitted to hospital with a severe brain injury. CT and MRI scanning demonstrated two of the triad of signs – an acute subdural haemorrhage and bilateral retinal haemorrhages. He was resuscitated, but remained gravely neurologically compromised and died in hospital on 2 June 2007. Immediately before admission to hospital, he had been in the care of a childminder, C, who was subsequently prosecuted for offences of homicide and cruelty. Before she was, a fact-finding hearing took place before Pauffley J in January and February 2009 in a Local Authority application in respect of her children F, G and H. Dr. Squier was instructed to prepare a report by the solicitors for C. She was initially reluctant to do so, but stated that she was willing to assist as part of a multi-disciplinary team. She subsequently prepared a report dated 8 December 2008, which was supplemented by detailed neuropathological findings. She gave evidence at the hearing before Pauffley J. In a judgment handed down on 9 February 2009, she concluded that the cause of A's death was traumatic head injury.

The charges

76.

> "**Case of F, G & H**
>
> 12. Between 2008 and 2009 you acted as an expert witness in the case of F, G and H in the Family Division of the High Court (The Family Court), a case which involved the death of a baby 'A' (at the age of ten months). **Admitted and found proved**
>
> 13. On 3 February 2009 you gave evidence, orally and by submitting and implicitly adopting a report dated 8 December 2008, in the Family Court. **Admitted and proved** In your evidence:
>
> a. you provided expert opinion evidence outside your field of expertise by giving evidence based in the field of paediatric medicine;
>
> b. you made assertions in support of your opinion which were insufficiently founded upon the evidence available to you in that you suggested that baby 'A' had choked thereby suffering a re-bleed in a chronic birth related subdural haemorrhage despite the evidence contained in the statements of Witness C (16.7.07, 23.1.09); Witness E (18.7.07); **Witness M (12.03.08)** and the Reports of Mr Richards (2.7.07, 12.4.08. 7.1.09); Dr. Cary (11.7.07, 11.11.07); Dr. Watkeys (8.1.08, 15.1.08); Mr Jayamohan (29.12..08); Dr. Gawne-Caine (3.12.07); **Amended under Rule 17(3)**."

The MPT's findings

13(a)

77. In her report of 8 December 2008, under the heading "Gastro-oesophageal reflux", Dr. Squier stated,

> "Choking can cause a rise in intra-thoracic pressure which will in turn lead to raised pressure in the veins of the brain. This may be sufficient to cause rupture and bleeding from the very thin walled vessels found in a chronic subdural membrane. These vessels rupture spontaneously so even a mild rise in intracranial pressure can cause fresh bleeding."

78. Professor Smith and Professor Thiblin a senior forensic pathologist at the Department of Forensic Medicine, Uppsala (to whose evidence on other topics the MPT attached little weight) both said that choking was for clinicians to deal with. The MPT accepted their evidence as it was entitled to do. Its finding on this sub-charge was justified.

13(b)

79. In her report of 8 December 2008, Dr. Squier expressed an unequivocal opinion about the events leading to the death of A: he suffered a subdural haemorrhage in very early life, showed signs of cerebral irritation (vomiting, feeding difficulties, seizure) due to the presence of subdural blood.

> "He choked, suffered a re-bleed and collapsed in April 2007 leading to his hospital admission."

In the course of this collapse he suffered prolonged hypoxia which caused extensive brain damage. She confirmed this opinion in response to the first question asked of her in cross-examination by counsel for the local authority.

80. At the end of the MPT's analysis of the foundation for Dr. Squier's opinion, it stated,

> "The Tribunal accepts that experts can have different opinions but (that) they have to be based on evidence."

It is implicit in that finding that it believed that there was no evidence for Dr. Squier's opinion that choking had been the immediate cause of A's collapse. Its analysis of the lay evidence in paragraphs 329 and 330 confirmed that that was its opinion. In paragraph 329, it referred to the evidence of the childminder, C, and stated correctly that she did not mention choking. It also referred to the witness statement of staff nurse M and quoted a passage from it. In paragraph 330, it noted the following

> "The Tribunal has noted that C's statements did not mention A choking. No mention is made in any of the other witness statements or in any of the expert reports that A had been choking. There is therefore no clinical, radiological or pathological support from other experts to support choking. The Tribunal is aware that witness C was Spanish speaking and

> witness M has translated as she was a Spanish speaker. The Tribunal has also noted that witness M's statement was taken a year after the child collapsed. The Tribunal does not consider the witness statement of M to be compelling evidence of choking."

81. These factual conclusions require heavy qualification. Miss Bradley QC, for Dr. Squier, took me through the material which was available to the MPT to demonstrate that there was contemporaneous evidence of gastro-oesophageal reflux and choking which medical experts, including two of those named in the charge, considered should be examined. In his evidence to the MPT, Professor Smith agreed. Consequently, it is not necessary to set out at length in this judgment the material which supported his opinion. All that it is necessary to state is that there was lay evidence of choking. C's seven year old child said when interviewed by a specialist police officer that A was trying to vomit and was choking. Staff nurse M, albeit in a witness statement taken 11 months later, said that C had told her that A had choked while she was feeding him. The clinical notes contain repeated reference to gastro-oesophageal reflux disorder, a condition consistent with choking. In a telephone conference between experts on 18 January 2008, Dr. Watkeys and Dr. Gawne-Cane agreed that the cardiac arrest could have been caused by choking. The MPT were entitled to conclude that there was no expert support for the conclusion that choking had led to A's collapse and admission to hospital, still less to Dr. Squier's opinion that the choke had caused a subdural re-bleed; but it was not entitled to find that there was no, or no real, evidence of choking for her to consider. The thrust of sub-charge 13(b), which the MPT was entitled to find proved, was that Dr. Squier had expressed an opinion outside her expertise in the teeth of the findings of other experts, who were in a position to express an expert opinion. When she came to give her evidence to Pauffley J, the only expert to whom she expressly deferred was Mr. Jayamohan, a consultant paediatric neurosurgeon.

Consequential findings

15 and 16

82. The MPT were right to conclude that Dr. Squier had failed to work within the limits of her competence, to be objective and unbiased and to pay due regard to the views of other experts and to have been irresponsible in relation to sub-charges 13(a) and (b), but wrong to find that Dr. Squier's report and evidence were misleading. What she did, in plain view, was to advance and stick to a hypothesis which she was in no position to support as a neuropathologist.

S

83. S was the sibling of a three month old male baby (Z). On 29 October 2007, paramedics were summoned to his home. No pulse was felt, but he had a pink frothy sputum running out of both nostrils and at the back of his throat, which was cleared by paramedic PB. He was rushed to hospital where, a few minutes later, a heartbeat and pulse were obtained. He had two cardiac arrests and died just under two days later on 1 November 2007. The local authority brought care proceedings in relation to S, which were determined by Eleanor King J on 8 May 2009. Dr. Squier prepared a report for the solicitors for the parents dated 31 January 2009, supplemented by a

response to questions dated 19 February 2009. She gave oral evidence on 7 April 2009. Eleanor King J found that Z was injured when his mother shook or shook and threw him down.

The charges

84.

"**Case of: S**

17. Between 2008 and 2009 you acted as an expert witness in the case of 'S' (A Local Authority and S) which involved the death of baby 'Z' (at the age of three months) in proceedings before the Family Court of the High Court (The Family Court). **Admitted and found proved**

18 On 7 April you gave evidence orally and by submitting and implicitly adopting a report dated 31 January 2009 and a document entitled 'Response to Question' dated 19 February 2009, in the Family Court. **Admitted and found proved** In your evidence:

a. you provided expert evidence outside your field of expertise based in the field of ophthalmology and/or ophthalmic pathology by opining that the retinal haemorrhages may have been caused by a hypoxic event;

b. you made assertions in support of your opinion which eere insufficiently founded upon evidence available to you in that you:

i. suggested that baby Z had suffered a choke which caused hypoxia leading to a subdural haemorrhage despite the evidence contained in the statements of Witness N (26.11.07, ~~12~~13.2.08, (1) 13.2.08, (2) 4th statement undated); Witness F (10.1.08, 9.3.09); Witness PB (11.11.07); Witness LD (11.11.07); and the reports of Dr. Peters (24.6.08) ~~and~~ Dr. Cary (19.5.08); **and the evidence of Dr. Peters; Amended under Rule 17(3)**

ii. relied on an error by Mr. Richards as to the head of circumference measurement for 22 August 2007, reported by him as being in the 91st centile.

c. You purported to rely upon research papers set out below whereas in fact that research did not support your opinion in the way in which you suggested namely that there was an ~~link~~ **association** between hypoxia and subdural bleeding: **Amended under Rule 17(3)**

a. Cushing H (1905);

e. You purported to rely upon research papers set out below whereas in fact that research did not support your opinion in the way in which you suggested namely that there was an association between choking and subdural and retinal haemorrhages:

i. Hylton C and Goldberg MF (2004);

ii. Martinez-Lage JF et al. (200).

19. You failed to present your reports and the research material you relied upon in a way which would allow other experts and parties to check your sources in that you made reference to two papers (Squier 2006 and Barnes 2008) which were case series abstracts which could not be found on a standard publications search."

The MPT's findings

18(a)

85. In her report dated 31 January 2009, Dr. Squier said that she did not think there was any unequivocal evidence of trauma and that the most likely cause of death was choking and severe hypoxia. She also stated,

> "I assume that the vessels of the retina being similar to the vessels in the brain, would be subject to similar damage by hypoxia and would also bleed on reperfusion."

In her evidence, when asked in cross-examination by counsel for the local authority whether she had anything to say about the causation for the retinal haemorrhages, she responded,

> "Retinal blood vessels – first of all, I am not an expert on the eyes. I do not look at eyes. I do not look into them in life and I do not look at the retina after death, but the retina is merely an outpost of the brain, as it were…"

She was then taken to task by counsel about the limits of her expertise. Her answers were as follows,

> "I think that I should be very restricted in the amount that I do comment on ophthalmological matters, because I do not look at eyes regularly."

> "…My area of expertise is the brain. I do not look at eyes. So I may look at what is in the rest of the body and in the clinical history to try and understand my own area of expertise, but I do not wish to go any further than that in trying to understand what is happening in the eyes."

The following exchange then occurred,

> "Q. Dr. Bonshek was asked to comment upon your assumption and he said that he regarded it as a false analogy. Are you content to accept that opinion from an ophthalmologist?
>
> A. Dr. Bonshek is the ophthalmic pathologist. I accept what he has to say.
>
> Q. Therefore your assumption does not stand?
>
> A. I would welcome the opportunity to discuss it with Dr. Bonshek to see exactly why he says that, but at this point with the information I have in front of me I will accept what Dr. Bonshek says in this case."

She later went on to say that she could see no reason why the eyes should be exempt from reperfusion injury,

> "But if Dr. Bonshek says I am wrong, then Dr. Bonshek's evidence is that which has to be considered. I would very much like to know the grounds on which he says that."

Later, when asked whether she deferred to ophthalmological opinion on the topic of extension of haemorrhages, she said,

> "Of course the three ophthalmologists must be deferred to, absolutely."

86. The MPT found this allegation proved. It was entitled to do so because Dr. Squier had expressed an opinion outside her expertise; but its findings should have been qualified by the recognition that, when pressed, she acknowledged the superior expertise of the ophthalmologists and deferred to the opinion of Dr. Bonshek on the uninformed assumption which she made in her report as to the similarity of causes of damage in the retina and in the brain.

18(b)(i)

87. As already noted, Dr. Squier identified the most likely cause of death as choking and severe hypoxia at the conclusion of her report of 31 January 2009. She was asked by the Court to advise "if you feel able" on the relevance, if any, of the history given by the mother of a choking episode followed by difficulty in and then cessation of breathing; and on the most likely cause of death. Her written answer on 19 February 2009 was choking and, in consequence, severe hypoxia, based on neuropathological findings and clinical description given by the mother of her baby "attempting to vomit" prior to collapse. She reiterated this opinion in her oral evidence.

88. The MPT correctly noted that Dr. Cary, Home Office pathologist and Dr. Peters, consultant paediatrician, concluded that inflicted head injury was the most likely cause of Z's fatal injury. Dr. Peters stated that it would be physically impossible for Z to continue crying, as he did, if he was suffering or had suffered a fatal choking event. The MPT also examined the fourth statement of Z's mother, made a year after the

event, in which she had mentioned that he had been trying to bring something up. It discounted it and, in the light of the expert evidence, based in part on what the paramedics had seen, concluded that there was no clinical, radiological or pathological support from other experts to support choking. This was a modest overstatement. Again, Miss Bradley has referred me to the material which does not exclude it, including clinical notes recording the presence of vomited milk in the throat and nose, a diagnosis by a paediatric registrar of an aspiration event leading to respiratory and cardiac arrest and to the preliminary diagnosis of Dr. Robert Ross Russell, the consultant in paediatric intensive care who examined Z on 30 October 2007 that his problems related primarily to his heart. Later, in a witness statement dated 29 November 2007, after the report of the post-mortem was notified to him, he expressed surprise that the possibility of non-accidental injury as a cause of his illness had been discussed.

89. The MPT's finding that there was no clinical support from other experts to support choking was, therefore overstated. Further, they made no reference to the evidence of Professor Luthert, an ophthalmic pathologist that, in the light of Z's mother's description, it was "plausible" that there was vomiting and choking before collapse. The MPT had, however, already decided to attach limited weight to his evidence because of inconsistencies in his answers. I am no position to judge whether or not that assessment was correct and must, therefore, accept the MPT's view about the weight to be given to his evidence. On that basis, it is unlikely to have made any material difference to the finding on this issue.

90. Even allowing for some overstatement of the absence of the evidence of choking, the MPT was entitled to find this sub-charge proved, essentially for the reasons which it gave.

18(b)(ii)

91. The MPT found this sub-charge proved. Mr Kark stated before Sir Robert addressed this sub-charge that it should have been amended. In consequence, he did not seek to sustain it on appeal. I need therefore say no more about it.

18(d)(i)

92. Dr. Squier made no reference to Cushing in her report. In cross-examination by counsel for the local authority about a research paper by Cohen and Scheimberg of 2009, she said that that paper was helpful in establishing an association between hypoxia and bleeding into the dura. A sub-charge of mis-citing that paper was withdrawn at the end of the GMC's case. Dr. Squier asserted in the same answer that that paper was not the first of its kind. "This association has been recognised since Cushing's studies of 1905". There was no further reference to it and it does not feature in the judgment of Eleanor King J. Professor Smith gave evidence before the MPT that the Cushing paper did not support Dr. Squier's opinion. There is, however, a sentence in the paper which does,

> "Whether these cortical haemorrhages in the cases which I examined had been the cause of death could not, of course, always be told, though in some of them the effusion of blood was so great that little doubt was felt that it must have played

> an important part in the asphyxiation which the clinical histories recorded."

That was a description of bleeding associated with hypoxia. Professor Smith explained to the MPT that Cushing was referring to a different condition from that addressed by Dr. Squier.

93. The MPT found this sub-charge proved, but only on the basis that it accepted Professor Smith's evidence that the Cushing paper did not support the suggestion of an association between hypoxia and bleeding into the dura. Given the terms of the sentence which I have cited, I doubt that that conclusion was open to them; but, given the difference between the language used by Cushing and that used by neuropathologists nowadays, this is not an issue which I can resolve satisfactorily. For the purposes of this appeal, all that I can safely conclude is that the reference to Cushing appears to have been a throwaway line by Dr. Squier in her evidence about another research paper. If it has any significance, it is minor. It is not capable of founding a charge that she misled the Court.

18(e)(i) and (ii)

94. In her report of 31 January 2009 Dr. Squier stated

> "There are well described cases in the literature of babies who have choked and presented with subdural and retinal haemorrhages (Hylton 2004, Martinez-Lage 2005)."

Neither report was as she described it. The Hylton paper gave a brief description of a single case: a five month old girl was admitted to hospital because of uncontrollable seizures. CT scans revealed bilateral subdural haematomas, interhemispheric and subarachnoid haemorrhages. Ophthalmological examination revealed bilateral retinal haemorrhages. A single sentence described the history given by her father,

> "Her father has shaken her vigorously, allegedly in an attempt to rescue her from a choking spell."

The end result was that the child was placed in foster care.

95. The Martinez-Lage paper also concerned a single 3 ½ month old baby, who was admitted to a paediatric intensive care unit having experienced an acute episode of loss of consciousness. The history described by the parents was,

> "The parents referred that the child became choked during food intake. The infant vomited, got a congested face followed by cyanosis, and became unconscious. During transport to an emergency department, the father applied the Heimlich manoeuvre shaking the baby forcefully."

A CT scan revealed an acute bilateral inter-hemispheric haemorrhage. Ophthalmic examination revealed bilateral retinal haemorrhages. These were classic indicators of injury caused by shaking, according to the majority view (which is reported to prevail in the United States where this study was undertaken). Social and forensic

investigations however supported the accidental nature of the child's injuries, leading the authors to describe them as "benign shaken baby syndrome".

96. On any view, both papers described classic brain injuries in babies following upon vigorous or forceful shaking. In the second case the shaking was accepted not to be abusive. In the first it must have been, because the choking incident was described as "alleged" and the baby was taken into foster care. On no reasonable view could the papers be described as "well described cases…of babies who have choked and presented with subdural and retinal haemorrhages".

97. Dr. Squier was effectively cross-examined about this statement by counsel for the local authority. She was driven to assert that the Hylton paper did not provide enough evidence so that "maybe we have to think that the choke itself could have been responsible" and that "on any logical analysis that shake could not possibly have been responsible for the pathology". In relation to the case described by Martinez-Lage she asserted that,

> "Any rational analysis of the behaviour of a parent trying to resuscitate a baby would preclude very violent shaking, despite the description that we are given in the paper."

She was, therefore, driven to concede that the cases were not "well described". This was the most striking of the occasions on which Dr. Squier was alleged to have mis-cited research papers. The MPT had evidence from Professor Smith and Dr. Bonshek confirming that analysis and that neither paper supported Dr. Squier's choking hypothesis. The MPT were right to come to the conclusion that they did on this sub-charge.

19

98. In the same paragraph of her report dated 31 June 2009, Dr. Squier referred to six cases of which she had personal experience, which she had presented as a peer reviewed oral presentation to the British Paediatric Neurologists Association (Squier 2006) and a further 11 cases presented and published in abstract form (Barnes 2008). Professor Smith stated that he had not been able to find either case series on a standard publication search. Dr. Squier's evidence to the MPT about her own case series was conflicting. The MPT had no reason to doubt Professor Smith's evidence and were entitled to find this sub-charge proved.

Consequential findings

20 and 21

99. The MPT were entitled to find that Dr. Squier had failed to work within the limits of her competence and to be objective and unbiased in relation to sub-charge 18(a), but not that she failed to pay due regard to the views of other experts, in particular Dr. Bonshek. It was also not entitled to find, as it did, that her actions and omissions were in this respect misleading or irresponsible. She stated her uninformed assumption openly and abandoned it, subject to speaking to Dr. Bonshek about the mechanism of retinal bleeding, when asked about it.

100. The MPT was entitled to find as it did, that Dr. Squier had failed to work within the limits of her competence and to be objective and unbiased and to have been irresponsible in relation to sub-charge 18(b)(i). Dr. Squier was expressing a positive opinion, that choking was the likely cause of injury, on the basis of the clinical history and should not have done so. The MPT should not, however, have found her actions and omissions to be misleading. She set out clearly the basis for her hypothesis. The fact that it was ill-founded did not make her actions and omissions misleading.

101. For the reasons explained above, no consequential findings were justified in relation to sub-charge 18(d)(i).

102. The MPT was right to find that Dr. Squier had failed to be objective and unbiased in relation to sub-charge 18(e) and, for the reasons already explained, that her actions and omissions in that respect were misleading and irresponsible. The MPT's finding that Dr. Squier's actions and omissions in this respect were deliberately misleading was also justified. As already noted, at the end of her cross-examination, she accepted that she understood the research very well. It would have been obvious to her that the Hylton and Martinez-Lage papers were not well described cases of babies who have choked. For someone who, like her, well understood the research, those words were calculated to mislead. They were far more than an unfortunate choice of words. Even if, because of her firmly held views about the triad, Dr. Squier had persuaded herself that the two cases described in the papers might, if more were known, support her hypothesis, she did know that, as written, they did not. She did, therefore, know that to describe them as "well described cases…of babies who have choked" was misleading.

103. The MPT were entitled to find that Dr. Squier's failure to present the reports and research material identified in sub-charge 19 was irresponsible was justified.

104. To the extent stated, the MPT's consequential findings were justified, but not otherwise.

SC

105. AC was the 17 month old step sister of SC. At about 7pm on 6 December 2005, while in the sole custody of her mother's partner, her step-father, she suffered a cardiac arrest and was taken to hospital. She died at 2am the next morning. She displayed all of the signs of the triad, together with acute axonal damage in the spinal cord and other injuries – rib fractures, external bruising to her face, arms and back and internal injuries. The step-father was prosecuted and tried by HH Judge Clegg and a jury in January 2008. In January and February 2010, Eleanor King J conducted a fact-finding hearing in family proceedings brought by the local authority in the case of SC. In a judgment given on 23 February 2010 she found that the step-father was responsible for the injuries caused to and death of AC. Dr. Squier prepared a report on the instructions of the step-father's criminal solicitors dated 6 June 2007. She gave evidence in the criminal case on 24 January 2008 and before Eleanor King J on 3 February 2010. This set of charges arises out of both cases.

The charges

106.

"22. Between 2008 and 2010 you acted as an expert witness in the case of S, C & Others which involved the death of child 'AC' (at the age of nineteen months) in criminal proceedings ad before the Family Division of the High Court (The Family Court). **Admitted and found proved**

23. On 24 January 2008 you gave oral evidence at the Crown Court having provided a report dated 11 June 2007 incorporating a reference list dated 6 June 2007. During the course of your oral evidence you:

a. provided expert opinion evidence outside your field of expertise by:

i. providing an opinion based in the field of paediatric neurosurgery as to how rapidly a brain might swell in a living person;

ii. providing an opinion based in the field of paediatric neurosurgery as to whether there may have been a lucid interval.

iii. providing an opinion based in the field of forensic medicine and post mortem pathology as to whether there may have been substantial subdural haemorrhage in child AC's brain.

b. provided expert opinion evidence in which you purported to rely upon the research paper set out below, whereas in fact that research did not support your opinion in the way in which you suggested namely that hypoxia leads to intradural bleeding:

Friede R (1989)

26. On 3 February 2010 you gave evidence, orally and by submitting and implicitly adopting a report dated 11 June 2007 incorporating a reference list dated 6 June 2007, in the Family Court. In your evidence you:

a. provided expert opinion evidence outside your field of expertise by:

i. providing an opinion based in the field of paediatric neurosurgery as to how rapidly a brain might swell in a living person;

ii. providing an opinion based in the field of paediatric neurosurgery as to whether

there may have been a lucid interval in a living person.

b. provided expert opinion evidence in which you purported to rely upon the research paper set out below, whereas in fact that research did not support your opinion in the way in which you suggested namely that hypoxia leads to intradural bleeding:

Friede R (1989);

c. provided expert opinion evidence in which you purported to rely upon the research paper set out below, whereas in fact that research did not support your opinion in the way in which you suggested namely that there was or may have been a lucid interval in respect of child AC:

e. provided expert opinion evidence in which you purported to rely upon the research paper set out below, whereas in fact that research did not support your opinion in the way in which you suggested namely that traumatic and ischaemic axonal injury could not be differentiated: **Amended under Rule 17(3)**

Oehmichen M (2008)"

The MPT's findings

107. Because of proper concessions made by Mr Kark, I can deal with the MPT's findings about the charges arising out of the criminal proceedings briefly. Two important preliminary points need first to be made.

i) At no stage was Dr. Squier's report of 11 June 2007 put before the jury. Any charge based on the premise that it was is, therefore, flawed.

ii) The passages in Dr. Squier's oral evidence cited in the charges all arose out of cross-examination by counsel for the Crown. The passages from the judgment of Auld LJ in *Meadow v GMC* cited in paragraph 59 above, are relevant as is a further passage from paragraph 506,

"…It is incumbent on the legal representatives on the other side not to encourage, in the form of cross-examination or otherwise, an expert to give opinion evidence which is irrelevant to those issues and/or outside his expertise, and, therefore, inadmissible."

That duty was not discharged by counsel for the Crown in this case.

23(a)(i) and (ii)

108. Dr. Squier was first asked about lucid intervals by counsel for the Crown 48 pages into the transcript of his cross-examination. It followed extensive cross-examination about injuries to AC other than to her brain – for example, the rib injuries, as to which she said she would accept what Professor Risdon said. The question which prompted the answers which were the subject of these two sub-charges was,

> "According to the evidence we've heard, for there to be a lucid interval, or a latent period, there would need to be a space - occupying lesion which is not what Professor Risdon describes at post-mortem is it?"

She gave a long answer, in which she explained her understanding of lucid intervals, including the following

> "Now, the brain will start swelling in response to injury within I think about 20 minutes is the generally accepted time, and the maximum swelling is at 24 to 30 hours, and this is certainly borne out by my own experience looking at babies who have suffered injury at birth."

When, later, counsel drew her attention to the evidence of Dr. Harding that the brain was not "really swollen at all", she accepted it and said,

> "I didn't see the brain fresh. Dr. Harding saw it when it was fixed. It's really a matter of Professor Risdon and Dr. Harding's evidence. But you can accept that, yes."

109. A little later, counsel asked her about a "scenario": if AC had sustained rib fractures four or seven days before death in an accident involving a hoover and was cuddled repeatedly thereafter, "wouldn't that have had some effect upon her?" When Dr. Squier said that he should ask somebody who was a clinical paediatrician or radiologist, he replied,

> "Q. But you are a mother, a parent."

She then answered his hypothesis.

110. This material shows that counsel for the Crown was, in the heat of the moment, not doing what was incumbent upon him, confining his questions to the expertise of the witness he was cross- examining. As is apparent from the passages cited, Dr. Squier did give evidence outside her expertise, about brain swelling and lucid intervals, but expressly conceded that it was a matter for Professor Risdon and Dr. Harding and that their evidence could be accepted. The MPT was, strictly, right to find these sub-charges proved, but in the context in which the evidence was given, the fact that Dr. Squier had responded to questions with answers outside her expertise was understandable.

23(a)(iii) and 23(b)

111. Because both sub-charges are based to a significant extent, in the case of 23(a)(iii), and wholly in the case of 23(b), on the contents of Dr. Squier's report of 11 June 2007, which was not in evidence in the criminal trial, Mr Kark has properly conceded that the MPT's findings on these charges cannot stand.

26(a)(i)

112. Dr. Squier did not repeat the statement which she made in the criminal proceedings about brain swelling in her evidence before Eleanor King J and did not state it in her report. The MPT's finding that she did is wrong.

26(a)(ii)

113. Dr. Squier made no reference to lucid intervals in her report of 11 June 2007. She was asked in-chief by counsel whether sheared axons were consistent with a collapse 3 ½ hours later to which she replied that she found it difficult to answer that question. At the end of her answer, she said,

> "A baby would have to collapse immediately, and it would have to be due to progressive brain swelling that the baby has a lucid interval. But now, I don't know. I don't think we have the evidence."

This is the only reference which I can find to anything said in her evidence-in-chief about lucid intervals.

114. Counsel for the local authority returned to the question in cross-examination, beginning with a reference to examination-in-chief which I cannot find in the transcript. The following exchange occurred,

> "Q. Can I move on from axonal damage please to what you said about lucid interval? What you said today, in answer to Mr Storey's question, your answer was "there is nothing I can see down a microscope that would exclude lucid interval". You would have to, would you not, defer to experts in other disciplines for whether, in fact, there was a space occupying lesion or a space occupying subdural haematoma causing mass effect on the brain? That is for others to tell us, is it?
>
> A. The only information we have about that comes from the autopsy findings, yes.
>
> Q. And perhaps the radiology?
>
> A. Yes. I wasn't aware that there was a space occupying mass on the CT scans, but yes, they would have to tell us.
>
> Q. Can I put to you the short point really, which is that Dr. Blunkett, Dr. Anslow, Mr Richards, Professor Risdon and Dr. Stoodley say "No mass effect space occupying lesion

> here", you would not want to go behind that or gainsay that?
>
> A. No. My impression from looking at the CT scans was that there wasn't one there and, at post-mortem, there was asymmetrical subdural bleeding. It was difficult to know if it was space occupying, because (I) didn't have a measurement. But, no, I would have to defer to the opinions of those who saw that bleeding."

Later on, the following question was asked,

> "Q. Mr Richards gave evidence that someone going through a lucid interval would be apparently well in the sense of conscious, but they would have a reduced Glasgow coma score. Is that something you agree with?
>
> A. It is something I really shouldn't be venturing into, because that's a clinical matter. "Apparently well" can be very different for an adult to a child, so I think it should be a clinician who deals with that."

115. I have quoted from those passages extensively, because they show that, when asked about lucid intervals, Dr. Squier expressly and more than once deferred to others. She did not stray outside her expertise. The MPT's finding that she did was wrong.

26(b)

116. Mr Kark conceded that the MPT should not have found this sub-charge proved.

26(c)

117. In her report of 11 June 2007, Dr. Squier commented on Mr. Richards' statement, as follows,

> "At 6.8 he suggests that severe head injury will not be compatible with normal behaviour and he attempts to time the injury from the clinical presentation.
>
> - *This is unsafe as there are many descriptions of infants who survive with mild or no clinical symptoms for some time after fatal traumatic head injury (Arbogast 2005)*"

118. I have already summarised the conclusions of the Arbogast paper at paragraph 45 above. She was invited to comment upon the Arbogast paper in cross-examination by counsel for the local authority. She agreed with Mr. Richards' view that "lucid" in the context of a lucid interval meant conscious, but with a reduced Glasgow Coma Score. She went on to make the points about which Professor Smith had taken her to task in O and F: it was extremely difficult to measure Glasgow Coma Scores in young infants and that any sort of trauma in the young brain is more likely to give a lucid interval in younger babies than in older babies. When asked by counsel whether the word "many" in front of "descriptions of infants who survive with mild or no clinical

symptoms for some time after fatal traumatic head injury" was appropriate, she referred to other papers that she had not cited, implicitly accepting that it was ill-chosen in relation to this paper. If Dr. Squier's evidence had been confined to her report above, Professor Smith's criticisms and the MPT's finding would have been justified; but it was not. Her evidence, taken as a whole, did refer to and accept Professor Smith's view about the proper use to which the Arbogast paper could be put. This finding was not justified.

26(e)

119. Dr. Squier made no reference to the 2008 Oehmichen paper in her report. In cross-examination by counsel for the local authority about the opinion of Dr. Harding. She volunteered the following answer,

> "…we have also got the subsequent findings of Oehmichen last year which actually correspond with my own experience and with others' experience that we cannot be sure."

She was asked to state the significance of this paper, to which she replied,

> "But he does say in this paper that the distinction between hypoxic and traumatic was almost impossible, because all of those babies who were in this category of shaken babies also had extensive hypoxic-ischaemic injury. I think he was unable to be sure that the injuries he was seeing in those locations were specifically due to the trauma."

She was then referred by counsel to a passage from the paper,

> "Unfortunately, in SBS cases, it is almost impossible to determine at which point hypoxia ischaemia as relative to survival time, and thus, to assess its impact on axonal transport."

She agreed that that was the passage to which she was referring.

120. Professor Smith cited part of another passage from the paper,

> "The AI (axonal injury) was due in part to a vasogenic event, and in part to traumatic impact. While vascular AI exhibited a zig zag, wavy, or focal pattern, traumatic AI revealed a diffusely scattered pattern or groups of AI along the axis of the axon [25, 46]. A discrimination was not possible in every case, because the phenomena often appeared to be of combined origin."

121. In its determination, the MPT did not go on to recite the remainder of the paragraph. This was unfortunate, because, had it done so, it would have realised that it did not bear out the proposition which Professor Smith and it drew from it. It read,

> "DAI (diffuse axonal injury) – characterised by a diffuse distribution of axonal lesions within the white matter of the

> whole brain – could not be demonstrated in any of our SBS cases. Unlike Shannon et al [49], we observed no injured axons in the medulla oblongata. In two cases, injured axons were established at the level of the cranio-cervical junction, in one of these cases additionally within the nerve roots."

122. The numbers in square brackets were references to the research papers of others. Thus, when Oehmichen and his colleagues were describing the zig zag, wavy or focal pattern of axonal injury along the axis of the axon, they were referring to what others had discerned. Their own analysis led them to conclude that a discrimination was not possible in every case; and they cited only two cases in which injured axons were established at the critical point – the cranio-cervical junction. In their abstract, they reported that they had examined tissue from 18 dead infants, less than one year old, for the purpose of their study.

123. Professor Smith stated, in evidence accepted by the MPT that the authors could discriminate between traumatic and ischaemic causes of axonal injury. In fact they only did so in 2 out of 18 cases. Unfortunately, this proposition was not put to Professor Smith in cross-examination. As a non-expert, I set out my understanding of the passage on which he relied with some diffidence, but it does, in the end, seem to me to be reasonably clear. It supports rather than undermines Dr. Squier's opinion. The MPT was wrong to find this sub-charge proved.

Consequential findings

24 and 25, 27 and 28

124. The only consequential finding which is justified is that Dr. Squier failed to work within the limits of her competence by giving evidence about brain swelling and a lucid interval in cross-examination in the Crown Court. As already noted, the fact that she did so was understandable.

Oyediran

125. On 18 October 2005 Oladapo Oyediran drove his son (F), aged two months and 10 days, to the Battersea Fields Medical Practice, arriving at about 11.10 am. F was seen by a doctor at the Practice at 11.44 am. He was dead. An autopsy was performed on 19 October 2005 by Professor Risdon. He observed two of the signs of the triad (subdural haemorrhage and brain swelling) and haemorrhage around the optic nerves, and concluded that the cause of death was NAHI. Oyediran was prosecuted for murder and convicted. He appealed to the Court of Appeal Criminal Division. He sought to rely on fresh evidence from two doctors, one of whom was Dr. Squier. She prepared a report dated 8 May 2009, an addendum dated 21 December 2009 and a further addendum (upon which nothing turns) dated 5 February 2010. She gave oral evidence to the Court, which it heard de bene esse. It refused permission to admit it formally and dismissed Oyediran's appeal.

The charges

126.

> "29. In March 2010 you acted as an expert witness for the appellant in the case of Oyediran in proceedings before the Criminal Division of the Court of Appeal, which involved an appeal against conviction in relation to the death of baby 'F' (at the age of two months). **Admitted and found proved**
>
> 30. On 24 March 2010 you gave oral evidence in the Court of Appeal (Criminal Division) having prepared and provided a report dated 8 May 2009 with an addendum dated 21 December 2009 and a second addendum report dated 30 January 2010 and 5 February 2010. **Admitted and found proved** In your oral evidence and in your reports (which were implicitly adopted by you) you:
>
> a. made an assertion in support of your opinion which was insufficiently founded upon the evidence available to you in that you suggested that paediatric HIV encephalitis may have been the cause of baby F's severe brain damage despite the evidence contained in the report of Professor Jeanne Bell (9.12.09);
>
> b. refused to change your opinion regarding the relevance of an HIV infection, notwithstanding a review of the brain by Professor Jeanne Bell, a recognised expert pathologist in paediatric HIV encephalitis, who concluded that there was no evidence of HIV-related disease."

The MPT's findings

30(a)(b)

127. In her report dated 8 May 2009 prepared for Oyediran's criminal solicitors, Dr. Squier commented on the reports of other experts and on her own analysis of stained sections taken at autopsy from F's brain. Under "Opinion" she stated,

> "The pathology is of a severe necrotising encephalopathy. It is not typical for hypoxic-ischaemic injury but is consistent with viral and HIV encephalitis although the pathology is not diagnostic.
>
> Specific HIV immunocytochemistry is negative, but this is not unexpected at this age.
>
> The presence of bruises and a fracture suggest that there was also trauma. It is not possible to tell if this was inflicted or accidental."

The reference to HIV immunocytochemistry arose because Dr. Squier sent sections to the neuropathology department in Edinburgh and the results were negative.

128. Before expressing her opinion, Dr. Squier reviewed possible differential diagnoses, hypoxic-ischaemic injury, viral encephalitis, HIV/AIDS, subdural bleeding, trauma and terminal aspiration of stomach content. She suggested that Professor Jeanne Bell be asked to review the brain because, although now retired, she had more experience than any other pathologist in the UK in paediatric HIV encephalitis.

129. Professor Bell did review the brain and produced a report dated 9 December 2009. In it, she expressed the opinion that the appearances of the central nervous system were not suggestive of a HIV infection nor was there any evidence of AIDS-associated opportunistic infections or lymphoma. If there had been, she would have expected to have detected the HIV protein p24 in a significant number of the microglia and macrophages. She also found that the distribution of tissue damage was unlike that generally seen in HIV encephalitis. She said that it was important to note that it was not possible categorically to rule out the possibility of HIV infection through examination of the brain alone. Her conclusion was,

> "In summary, while it is not possible to be absolutely certain, I do not think that the changes in this brain represent HIV encephalitis or any other condition associated with AIDS. My investigation has been rendered incomplete because of non-availability of organ blocks in this case."

130. In her addendum, after receipt of Professor Bell's report, Dr. Squier stated,

> "I note that she is unable to establish the diagnosis of HIV encephalitis, nor to be absolutely certain that it was not the cause this baby's severe brain damage. She does not think the pathology is due to any form of HIV-related disease or AIDS. Diagnosis is hampered by the failure to retain non-brain tissue from the baby and the incomplete autopsy on the mother.
>
> Conclusion
>
> HIV encephalitis has not been confirmed as the cause of this baby's severe brain damage, but cannot be fully excluded.
>
> With regard to the list of differential diagnoses set out above, hypoxic-ischaemic injury remains the most likely cause. The cause of this cannot be established but trauma is one possibility and the fractured humerus is evidence that some form of trauma has occurred.
>
> The damage is old and has been present for some weeks. I do not believe that the baby can have been behaving at all normally since the brain damage and should have been brought to medical attention.
>
> The cause of death is most likely to have been aspiration of feed or vomit secondary to the severe brain damage."

131. In her evidence to the Court of Appeal, she said that the diagnosis of HIV infection could not be completely excluded, although there was nothing which pointed positively to it. Her explanation for her choice of words was that she could not be certain from Professor Bell's comments that HIV could be excluded.

132. The MPT found both sub-charges proved. The foundation for their finding was essentially the same: that Professor Bell's report was clear and gave sufficient certainty for HIV to be excluded. In consequence, Dr. Squier persisted with a possible diagnosis which was "a vanishingly small possibility". In addition, in relation to sub-charge 30(a), the MPT determined that she had investigated the possibility of HIV simply on the basis of his father being from Nigeria.

133. The latter conclusion was not a fair or accurate summary of that part of Dr. Squier's reasoning which, as the cited passage of her opinion shows, was founded, at least in part, on the brain pathology.

134. The principal conclusion was, however, well-founded. Professor Bell's report and the negative result of HIV immunocytochemistry did all but exclude the hypothesis of HIV/AIDS infection. Dr. Squier's choice of words in her addendum demonstrates it was not a hypothesis that she was willing to discount. The MPT were entitled to find both allegations – in reality – one allegation – proved.

Consequential findings

31 and 32

135. The MPT were entitled to find that Dr. Squier had not been objective and unbiased and failed to pay due regard to the views of other experts, i.e. Professor Bell. It was also entitled to find that her actions and omissions in this respect were irresponsible. But it was not entitled to find that they were misleading or deliberately misleading. In their finding about dishonesty which, for reasons already explained, they should not have made, they revealed a disturbing lack of understanding and overstatement about what had occurred,

> "You were completely intransigent as to the possibility of a differential diagnosis. You had based your opinion upon complete speculation due to the origin of baby F's father despite a lack of neuropathological evidence. By manipulating the opinion Professor Bell gave you created uncertainty in the Court of Appeal…"

The first sentence is wrong. The MPT were entitled to conclude that Dr. Squier had been intransigent about the possibility of excluding, for all practical purposes, HIV infection as the underlying cause of the pathology which she had seen. She was not, however, intransigent about the possibility of a differential diagnosis. In the cited conclusion to her addendum, she considered the list of differential diagnoses set out in her report of 8 May 2009 and concluded that the cause of the hypoxic-ischaemic injury which in her view was the most likely cause could not be established, but trauma was one possibility. She also made the commonsense observation that the fractured humerus was evidence that some form of trauma had occurred. The second sentence was also wrong. Her opinion was not based only on speculation about the

father's origin, but was also based on the neuropathology. The third sentence was serious mischaracterization of what she did with the opinion of Professor Bell. She did not manipulate it. She misstated it in words which were obviously going to be scrutinised later on the basis of Professor Bell's report. Finally, she did not mislead the Court of Appeal, which did not formally admit her evidence and dismissed the appeal based on it.

136. For the reasons given, the MPT were not entitled to find that her actions and omissions were misleading or deliberately misleading.

Conclusions

137. For the reasons explained in the preceding paragraphs of this judgment, the determination of the MPT is in many significant respects flawed. That will require the decision on impairment and sanction to be retaken. My provisional intention, subject to further submissions to the contrary, is that I should exercise the powers given to me under CPR 52.10(1) to make both decisions myself.

Concluding observation

138. This was a lengthy and complex case. Its principal focus was the preparation and giving of expert evidence in family and criminal proceedings. Both for reasons of case management and of understanding the context in which expert evidence is given in such proceedings, it would have been desirable for this MPT to have been chaired by a lawyer with judicial experience. The Medical Practitioners' Tribunal Service is obliged to maintain a list of tribunal members, including lay members, under Rule 4 of the General Medical Council (Constitution of Panels, Tribunals and Investigation Committee) Rules 2015. A "lay" member means a person who is not and has never been registered: rule 2. A lawyer with judicial experience falls within this definition. The MPTS is required by Rule 6(4) to maintain a list of persons eligible to serve as chair of a tribunal, including "lay" members. There is, therefore, nothing in the 2015 rules to prevent a lawyer with judicial experience from being appointed to chair a complex case requiring an understanding of the context in which expert evidence is given in a court. It would, in hindsight, have been better if that power had been exercised in this case.