General Medical Council

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Fitness to Practise Panel
Dr Alan Roy Williams
3 June 2005

"That, being registered under the Medical Act,

'1. At all material times you were,

a. Employed as a Consultant Histopathologist at Macclesfield General Hospital,
Admitted and found proved

b. A forensic pathologist accredited by the Home Office Policy Advisory Board for Forensic Pathology;
Admitted and found proved

Christopher Clark

'2. a. On or about 16 December 1996 you performed a post mortem examination of Christopher Clark, aged 12 weeks, at the request of HM Coroner for Cheshire.
Admitted and found proved
(Although a Coroner's post mortem, the possibility of unnatural death was recognised and whether it continued as a Home Office or Coroner's post mortem depended upon your findings and discussion)

b. You reported that on external examination you had found frothy muco pus coming from the nose,
Admitted and found proved

c. On internal examination you noted appearances which you subsequently reported as,

i. small amounts of muco pus in the trachea and bronchi,
Admitted and found proved
ii. acute serosal inflammation in the lower lobes of the right lung,
Admitted and found proved

iii. slight grey linear deposits on the surface of both the right and lower lobes (sic),
Admitted and found proved
iv. the lungs were slightly oedematous on compression,
Admitted and found proved

d. On sectioning, you found no macroscopic evidence of pus or consolidation,
Admitted and found proved

e. You took cultures and histology from various sites, including the lung and spleen;
Admitted and found proved

'3. a. You prepared a post mortem examination report,
Admitted and found proved

b. Your report stated that you had found,

i. a bruise over the posterior aspect of the right elbow half a centimetre,
Admitted and found proved
ii. a reddened area at the base of the right thumb half a centimetre and an erythematous reddened area over the interphalangeal joint of the right thumb half by half a centimetre,
Admitted and found proved
iii. a bruise on the anterior aspect of the left thigh, one by half, a further bruise below two by one, a bruise on the back of the right thigh half by half and below a further bruise half by half cm; a bruise on the left knee quarter by quarter cm and below this a further bruise a quarter by quarter cm, and on the back of the left calf a bruise half by half a centimetre,
Admitted and found proved
iv. a small split and slight bruising into the frenulum between the upper lip and jaw,
Admitted and found proved

c. You did not make a contemporaneous diagrammatic record of your findings in relation to the upper frenulum at the time of your post mortem examination,
Admitted and found proved

d. You reported as follows,

"In summary, this is a well nourished male infant 12 weeks of age showing evidence of respiratory tract infection with inflammation of the right lower lobe of lung predominantly. Cultures and Histology have been taken.

In my opinion the cause of death is 1a) Lower respiratory tract infection.",
Admitted and found proved

e. You reported that post mortem histology showed,

i. focal acute inflammation of the lung,
Admitted and found proved
ii. focal haemorrhages and inflammation of the spleen,
Admitted and found proved

f. Post mortem histology did not show,

i. any or any significant focal acute inflammation of the lung,
Found proved
(Please see determination for further clarification)
ii. any or any significant inflammation of the spleen,
Found proved
(The Panel accepted the uncontradicted expert evidence that you had misinterpreted extra medullary haemopoesis as inflammation)

g. You also made a statement in which you stated inter alia,

"I produce the report of my findings which are true in every detail and the signature at the foot is in my own handwriting.",
Admitted and found proved

h. You failed to exercise reasonable care and skill in interpreting and/or reporting upon the slides of the lungs and/~~or~~ the spleen,
Found proved
(The nature and extent of your errors left the Panel in no doubt that you had failed to exercise reasonable care and skill)

i. In your report you,

i. failed to discuss the possible significance of your reported findings as set out at head 3.b. above,
Found proved
ii. failed adequately to discuss the possible causes of death,
Found proved
iii. gave the cause of death as "1a) Lower respiratory tract infection" when this did not have a proper scientific basis,
Found proved

iv. should have given the cause of death as "Unascertained";
Found proved

(The Panel is satisfied that you had a duty to discuss your findings in respect of the unexplained injuries)

'4. In respect of heads 3.c., 3.e., 3.f., 3.g., 3.h. and 3.i.,

a. You failed to discharge the duties of a competent pathologist in such circumstances,
Found proved
(The Panel regarded all but 3c to be self-evident. 3c put emphasis on the important finding of an unexplained torn frenulum. Furthermore, the Home Office PABFP guidelines emphasise the importance of diagrams which are a secure medium for recording facts unlike photographs which, as in this case, can fail)

b. Your post mortem consideration and treatment of Christopher Clark was such that it impaired the reliable evaluation of the evidence of the cause of Christopher's death;
Found proved
(The death was not treated as suspicious and this precluded further investigation)

'5. a. On or about 27 January 1998 you were instructed by the Cheshire Police to carry out a post mortem examination of Harry Clark, aged 8 weeks, the brother of Christopher Clark,
Admitted and found proved

b. You carried out the post mortem examination on 27 January 1998 at Macclesfield Hospital Mortuary;
Admitted and found proved

'6. a. On or about 16 July 1998, Mrs Sally Clark was charged with the murders of Christopher and Harry Clark,
Admitted and found proved

b. You were ~~instructed~~ retained as an expert witness ~~for~~ by the Crown in relation to such prosecution,
Admitted and found proved as amended

c. You were under a duty to use your best endeavours,

i. to provide fair, comprehensive, accurate and objective expert evidence in advance of the trial,
Found proved
(The Home Office PABFP Guidelines are mandatory. If anything material is omitted other important lines of enquiry might be inhibited)

ii. to give fair, accurate and objective evidence if called as a witness at committal proceedings,
Admitted and found proved
iii. to give fair, accurate and objective evidence if called as a witness at trial;
Admitted and found proved

'7. a. On or about 6 August 1998 you made a statement under section 9 of the Criminal Justice Act 1967 in which you said that following the death of Harry Clark, you had reviewed the sections of Christopher and your post mortem findings and concluded,

> "In the light of these findings, I am no longer of the opinion that Christopher died of natural causes and there is evidence suggestive that he died from an asphyxial mechanism such as smothering.",
> **Admitted and found proved as amended**

b. On or about 25 May 1999 you gave evidence for the Crown at the committal proceedings, and you,

> i. rightly contradicted your earlier opinion and said that, on review and given your other findings, you did not think that the small amount of inflammation present in the lung was sufficient to explain Christopher's death [TS p80 l.21 to p81 l.6],
> **Found proved**
> ***(The panel is satisfied that you were right to contradict your earlier opinion because it was not scientifically valid)***
> ii accepted that your statement recited at head 7.a. above was not an opinion as to fact but the assertion of a possibility [cross-examination when recalled, TS p21 ll. 10-14],
> **Admitted and found proved**

c. At a meeting of experts on or about 9 September 1999, you rightly accepted that there were no significant features of respiratory infection,
Found proved
(You agreed the report of the meeting was accurate in the course of your evidence to the panel)

d. On or about 11 October 1999, Mrs Sally Clark appeared at Chester Crown Court charged with the murder of Christopher and Harry Clark and you were called as an expert witness ~~for~~ by the Crown at her trial,
Admitted and found proved as amended

e. On or about 14 October 1999, during evidence in chief, you said,

"My conclusion from the evidence I have before me is that this child has died from smothering" [TS p19 E-F],
Admitted and found proved

f. In cross-examination,

i. you said that you did not stand by your interpretation of the slides that Christopher was suffering an infection or inflammation [TS p52 A-B],
Admitted and found proved
ii. you said that you had been incorrect giving the original cause of death as lower respiratory tract infection [TS p 52 C],
Found proved
iii. you said that there was no significant inflammation [TS p52 C-D],
Found proved
iv. you said that you were sure that the lung slides showed some focal acute inflammation but that it was very minor [TS p53 A-B],
Admitted and found proved
v. you accepted that there was a possibility that Christopher was smothered, which you described as "a possibility in a broad range" [TS p59 A-B];
Admitted and found proved

'8. In your report, your written statement and your oral evidence relating to Christopher Clark,

a. You were incompetently self-contradictory,
Found proved.
(Your original opinion was wrong; it was therefore incompetent of you to provide an opinion, which you would later be obliged to contradict)

b. You failed to use your best endeavours to express fair, accurate and objective expert opinions;
Found proved
(The Panel accepts there was no bad faith on your part, but the nature and extent of your erroneous opinions amounted to a failure to use your best endeavours)

Harry Clark

'9. a In the course of your post mortem examination of Harry Clark, you removed his eyes,
Admitted and found proved

b. i. you reported that on opening the orbits of Harry's eyes at post mortem, there was an area of haemorrhage about 7mm across on the supero-lateral surface of the right eye, and a small area of haemorrhages about 2mm across on the lateral aspect of the left eye,
Admitted and found proved
ii. one or both of these appearances resulted from ~~incompetent~~ dissective contamination,
Found not proved, as amended
(In the light of the expert evidence, the Panel is not satisfied that this allegation had been proved)

c. i. you took ~~or caused to be taken~~ a sample of vitreous humour from one or both of Harry's eyes before laboratory dissection and/or block selection,
Admitted and found proved, as amended
ii. you thereby risked the compromise of the quality of the resultant microscope slides and/or any subsequent specimens from the eyes,
Found proved
(All the experts agreed that there was a risk, although they differed as to the extent)

d. i. Harry's eyes should have been submitted to an expert in ophthalmic pathology for laboratory dissection and block selection,
Found not proved
(The Panel is not satisfied that, in 1998, it was unreasonable for you to have prepared the eyes)
ii. the laboratory dissection and/or subsequent block selection should not have been delegated to a technician,
Admitted and found proved
iii. having removed the eyes, you conducted the laboratory dissection and subsequent block selection of the eyes
Admitted and found proved as amended
iv. you thereby risked the compromise of the quality of the resultant microscope slides and/or any subsequent specimens from the eyes,
Found proved.
(However, the Panel considers that, in 1998, this was a matter for your reasonable professional judgment)

e. i. the eye histology should have been submitted to an expert in ophthalmic pathology for microscopic examination,
Found proved.
(The Panel found that the eyes were submitted to an appropriate expert. There is no criticism of you in this respect)

ii. you microscopically examined the eye histology and concluded that both eyes showed extravasation of blood into the retinas,
Admitted and found proved
iii. this conclusion was incorrect,
Admitted and found proved

f. You were not competent to conduct laboratory dissection and/or block selection and/or microscopic examination of Harry's eyes to the level of expertise appropriate and necessary for a forensic case of this nature,
Found not proved

g. You were, in the circumstances alleged at heads 9.b., 9.c., 9.d. and 9.e. above, ~~incompetent~~ inadequate in your post mortem consideration and treatment of Harry's eyes.
Found proved in relation to 9eii and 9eiii, as amended
(You did not manifest the required level of skill on this occasion)

'10. a. On external examination you noted no injury or bruising to the back,
Admitted and found proved

b. On opening the spinal column you noted no evidence of bruising in the muscles of the back,
Admitted and found proved

c. On opening the spinal canal, you found appearances which you described in your report as follows,

"haemorrhage is found with some haemosiderin discolouration extending from the lower cervical spine down to the upper lumbar spine. The spinal cord is tight within the canal. There is some evidence of swelling of the cord within the dura. The dura and spinal cord were removed in entirety for subsequent fixation....",
Admitted and found proved

d. You conducted the laboratory dissection and block selection of the spinal cord ~~or caused or permitted a technician to conduct one or both of these tasks~~
Admitted and found proved as amended

e. The spinal cord should have been submitted to an expert in neuro-pathology for microscopic examination,
Found proved.
(The Panel found that, in due course, it was submitted to an appropriate expert)

f. Upon microscopically examining the histology you concluded,

i. that there was some subdural haemorrhage of the spinal cord,
Admitted and found proved
ii. that the spinal cord appeared oedematous,
Admitted and found proved
iii. that there was acute inflammation and bruising in the paraspinal muscles,
Admitted and found proved

g. Your conclusions at heads 10.f.i., ~~10.f.ii~~. and 10.f.iii. above were incorrect,
Insufficient evidence adduced to find proved in relation to 10.f.ii
Found proved in relation to 10fi and 10fiii
(The Panel is satisfied from the expert evidence that there were no more than occasional red cells and that this finding did not support the conclusions at 10fi and 10fiii)

h. You were not competent to conduct microscopic examination of Harry's spinal cord and/~~or~~ paraspinal muscles to the level of expertise appropriate and necessary for a forensic case of this nature,
Found proved
(Your erroneous findings in these two key areas satisfied the Panel that you were not merely inadequate but incompetent)

i. you were, in the circumstances alleged at heads 10.a. to 10.g. inclusive above, incompetent in your post mortem consideration and treatment of Harry's spinal cord and/~~or~~ paraspinal muscles;
Insufficient evidence adduced to find proved in relation to 10.f.ii
Found proved in respect of the remainder
(Please see clarification in relation to 10h above)

'11. a. On opening the ~~brain~~ skull you found appearances which you later described in your report as follows,

> "There is slight haemosiderin discolouration of the anterior parts and inferior parts of the right temporal lobe.",

Admitted and found proved as amended

b. i. the brain should have been submitted to an expert in neuro-pathology for laboratory dissection and/or block selection,
Found proved.
(The Panel accepted the evidence of the experts, who agreed that its preparation had caused difficulties in interpretation)

ii. the laboratory dissection and/or subsequent block selection should not have been delegated to a technician,
Admitted and found proved
iii you fixed the brain and subsequently conducted the laboratory dissection and block selection on or about 6 February 1998 ~~or caused or permitted a technician to conduct one or more of these tasks~~
Admitted and found proved as amended
iv. you thereby risked the compromise of the quality of the resultant microscope slides,
Found proved
(Please see clarification in relation to 11bi)

c. i. the brain histology should have been submitted to an expert in neuro-pathology for microscopic examination,
Found proved.
(The Panel found that it was eventually submitted to an appropriate expert. Please also see clarification in relation to 11bi)
ii. you examined the brain histology and reported that there were occasional contusional tears containing red blood cells (i.e. not artefactual),
Admitted and found proved
iii. this conclusion was incorrect,
Found proved
(The Panel accepted the evidence of the main body of experts, notwithstanding the dissenting opinion of Dr Armour)

d. You were not competent to conduct dissection and/~~or~~ block selection and/or microscopic examination of Harry's brain to the level of expertise appropriate and necessary for a forensic case of this nature,
Found proved.
(The nature of the case was an infant with a high index of suspicion of unnatural death)

e. You were, in the circumstances alleged at heads 11.a., 11.b. and 11.c. above, incompetent in your post mortem consideration and treatment of Harry's brain;
Found proved
(Taking the findings of 11a, b and c together the Panel is satisfied that you fell below the standard of a competent pathologist)

'12. a. In your reports, you stated that the second right rib in the lateral aspect showed a small area of callus formation, that the costal cartilage of the right first rib was dislocated from the end of the bony section of the rib, and that there was "possible old fracture of the right second rib",
Admitted and found proved

b. At the time of your post mortem examination,

i(a) you did not make a diagrammatic ~~or other~~ record of your observations in relation to Harry's ribs,
Found proved as amended
i(b) you did not make any other record of your observations in relation to Harry's ribs,
Found not proved as amended
ii. you did not cause any photographic record to be made of the macroscopic appearance of your observations in relation to Harry's ribs,
Admitted and found proved
iii you thereby failed to make any or any adequate contemporaneous record of such observations,
Found proved.
(The Panel found that there was a lack of systematic notes which would enable others to grasp the findings)

c. You took or caused to be taken samples in respect of a rib or ribs for the purposes of histology ("the samples"),
Admitted and found proved

~~d. You did not take and/or were not able to produce a sample or slide in respect of the right first rib,~~
Insufficient evidence adduced to find proved

e. You did not report on the histology of the samples taken in Versions 1, 2, 3 or 4 of your post mortem reports,
Admitted and found proved

f. You made statements pursuant to section 9 of the Criminal Justice Act 1967,

i. on 6 October 1999, in which you said that you had taken a photograph of the histological sections to show the healing fracture in the right second rib,
Admitted and found proved

ii on 18 October producing photographs which you described as being from a section showing healing fracture of a rib from Harry Clark and from a section showing a normal rib from Harry Clark,
Admitted and found proved

g. You did not otherwise report on the histology of the samples taken in your statements made in the criminal proceedings against Mrs Clark,
Admitted and found proved

h. ~~You did not undertake histological analysis of tissue in respect of the right first rib,~~
Insufficient evidence adduced to find proved

i. You were, in the circumstances alleged at heads 12.b., ~~12.d~~., 12.e., 12.g. and ~~12.h~~. above, incompetent in your post mortem consideration and treatment of Harry's ribs,
Insufficient evidence adduced to find proved in relation to 12d and 12 h
Found proved in relation to 12b, 12e and 12g
(Taking these matters together the Panel was satisfied that you fell below the standard of a competent pathologist)

j. In the respects at heads ~~12.d~~., 12.e., 12.f., 12.g. and ~~12.h~~. above, you failed to use your best endeavours to provide comprehensive expert evidence in advance of the trial;
Insufficient evidence adduced to find proved in relation to 12d and 12h
Found proved in relation to 12e, 12f and 12g
(The Panel considers that, although you were acting in good faith, your errors amounted to a failure to use your best endeavours because your reports were not compiled on the basis of comprehensive and contemporaneous notes, as required by Home Office PABFP. Moreover, you failed to discuss your histology findings in relation to Harry's ribs)

'13. In the respects set out at heads 9. and/or 10. and/or 11. and/or 12. above, your post mortem consideration and treatment of Harry Clark was such that it impaired the reliable evaluation of the evidence of the cause of Harry's death;
Found proved

'14. a. In the course of the post mortem examination you took swabs and/or samples from Harry's blood, faeces, lung tissue, bronchus, trachea, cerebro-spinal fluid, stomach tissue and stomach fluid,
Admitted and found proved

b. These swabs/samples were sent to the microbiology laboratory of Macclesfield District General Hospital for analysis,
Admitted and found proved

c. The results were reported in the terms and on or about the dates set out in Schedule 1 (i.e. between about 27 January 1998 and 18 February 1998),
Admitted and found proved

d. You,

i. received copies of those reports shortly thereafter and/or,
Admitted and found proved
ii. became aware of their contents shortly thereafter and/or,
Admitted and found proved
iii. had access to the results on the hospital computer system,
Admitted and found proved

e. Samples of blood, vitreous fluid and cerebro-spinal fluid were submitted for biochemical analysis, and reported upon by Dr Robins, Clinical Biochemist, on or about 3 February 1998,
Admitted and found proved

f. Dr Robins reported that the level of protein in the cerebro-spinal fluid was 3.24 grams per litre,
Admitted and found proved

g. You,

i. received a copy of this report shortly thereafter and/or,
Admitted and found proved
ii. became aware of its contents shortly thereafter and/or,
Admitted and found proved
iii. ~~had access to the report on the hospital computer system;~~
Amended

'15. a. Between about 29 January and about 13 February 1998 you prepared a report ("Version 1") in which you stated,

"There is no evidence of acute infection or inflammation, particularly there is no evidence of pneumonia, tracheo bronchitis nor meningitis. There is no evidence that this child died as a result of natural disease.",
Admitted and found proved

b. In the conclusion of this report you stated,

"The pattern of injury is that which is seen in shaking ..... The post mortem findings were those of a child shaken on several occasions over several days.",
Admitted and found proved

c. You gave a copy of this report to DI Gardiner on or about 13 February 1998;
Admitted and found proved

'16. a. During February and March 1998, parts of certain of the microbiological samples were sent to the Central Public Health Laboratory, Colindale, London for further testing of the staphylococcus aureus isolates,
Admitted and found proved

b. On or shortly after 3 March 1998, you received a letter from Dr Wills, Consultant Microbiologist, enclosing copies of the results of such testing. The letter concluded,

> "in the absence of any localised inflammatory response and in the absence of any suggestion of immune deficiency, I think it is unlikely that this organism contributed to the death of the child. It is somewhat unusual to find a contaminating organism so widely spread and it may be that there was a transient or terminal bacteraemia.",
> **Admitted and found proved**

c. On or before 1 July 1998 you made a witness statement pursuant to section 9 of the Criminal Justice Act 1967 in which you repeated the contents of Version 1 with an additional comment entitled "Time of Feeding" ("Version 2"),
Admitted and found proved

d. On or about 1 October 1998 you prepared and submitted to the HM Coroner for Cheshire a report dated 1 October 1998 ("Version 3"), in which you repeated the contents of Version 2 with additional comments about a lesion on the left cheek and the performance of the second post mortem,
Admitted and found proved

e. On or about 23 October 1998, you prepared a post mortem examination report ("Version 4") repeating the contents of Version 3, but adding on page 7 that the Cause of Death was 1a Shaken Baby Syndrome;
Admitted and found proved

'17. a. Your statement, in Versions 1, 2, 3 and 4 of your report that

> "There is no evidence of acute infection or inflammation, particularly there is no evidence of pneumonia, tracheo bronchitis nor meningitis. There is no evidence that this child died as a result of natural disease"

implied that you knew of no evidence of, or which might suggest, acute infection or inflammation including meningitis,
Admitted and found proved

b. The microbiology and/or biochemistry results were relevant to and/or tended to cast doubt upon the report that there was no evidence of, or evidence which might suggest, acute infection or inflammation including meningitis,
Found proved.
(Drs Anscombe, Rushton, Armour, Wills, Professors Berry, David and Morris all considered that the microbiological findings on Harry raised an element of uncertainty. Professor Eykyn disagreed. Dr Williams admitted in evidence to the Panel that there was "a slight possibility" that the staphylococcus aureus contributed to Harry's death. He also accepted that the spread of staphylococcus aureus, raised protein and polymorphs in the CSF might have been of assistance to the Defence)

c. Versions 1, 2, 3, 4 and/or each of them were not fair, comprehensive, accurate or objective in that,

i. they omitted reference to and discussion of the microbiology and/~~or~~ biochemistry results, particularly of the presence of staphylococcus aureus in the cerebro-spinal fluid and elsewhere, polymorphs and elevated protein,
Found proved

ii. they wrongly implied that the microbiology and biochemistry results were neither evidence of nor contained evidence which might suggest acute infection or inflammation including meningitis,
Found proved
(The Panel is satisfied that you had a duty to disclose, to others, their potential significance, regardless of your own views of the results)

d. By your said conduct, you wrongfully failed and/or chose not to refer to the microbiology or biochemistry results in Versions 1, 2, 3 or 4 of your report;
Found proved
(Dr Anscombe and Dr Armour agreed that you should have made reference to the results in your report. The Panel is satisfied that it was important for you to do so and, therefore, wrong for you to omit them)

'18. You wrongfully failed and/or chose not to disclose the microbiology and/or biochemistry results,

a. To HM Coroner (microbiology only),
Found proved
(see clarification under head of charge 17b,cii and d)

b. On or about 22 September 1998, at the time of a second post mortem examination of Harry Clark performed by Dr Rushton and Professor Emery on the instructions of Mrs Clark,
Found proved

c. In response to a letter dated 20 April 1999 sent to you by Messrs Forshaws, solicitors acting for a child the subject of care proceedings in the High Court of Justice, Family Division,
Found proved

d. On or about 25 May 1999 to the court, at the committal proceedings against Mrs Clark,
Found proved

e. On or about 4 August 1999 when Professor Berry and Professor David visited you at Macclesfield District General Hospital in connection with the care proceedings, ~~in which you were instructed as an expert on behalf of the Local Authority~~,
Found proved as amended

f. On or about 9 September 1999 at a meeting of experts in the care proceedings,
Found proved

g. Otherwise in the care proceedings;
Found proved
(In respect to 18a – g, you failed to disclose the results but there was no intention to mislead)

'19. a. In your capacity as an expert witness for the Crown, you were under a duty to share the fact and/or arguable significance of the results of the microbiology and/or biochemistry tests with,

i. the Police and/or the Crown Prosecution Service,
Found proved
ii. the experts instructed on behalf of the Crown (except perhaps Professor Green),
Found proved
iii. the experts instructed on behalf of Mrs Sally Clark,
Found proved

(Dr Anscombe stated that the duty of disclosure rested on the pathologist retained by the Crown, regardless of the questions asked or not asked by

Defence. Moreover, this is congruent with the Home Office PABFP guidelines. Dr Armour agreed with Dr Anscombe that it is the duty of the Crown pathologist to disclose information which may assist the Defence. The Panel was satisfied that you were under such a duty)

b. You wrongfully chose not to or failed to share the fact and/or arguable significance of the results of the microbiology and/or biochemistry tests with,

i. the Police and/or the Crown Prosecution Service,
Found proved
ii. the experts instructed on behalf of the Crown (except perhaps Professor Green),
Found proved
iii. the experts instructed on behalf of Mrs Sally Clark,
Found proved
iv. the court;
Found proved

(The Panel is satisfied that you failed in your duty as set out under head of charge 19a, but there was no evidence that you intended to mislead)

'20. a. On or about 29 October 1999, during the evidence of Professor David, the jury sent a question asking "Are there blood test results for Harry?" (Transcript p29),
Admitted and found proved

b. Later (p50) the jury sent a question asking "Why did Professor David analyse Christopher's blood for disease but did not analyse Harry's for comparison?",
Admitted and found proved

c. Professor David was invited to respond and replied that a sample was not collected from Harry to measure the chemicals in his blood,
Admitted and found proved

d. Later you were recalled by agreement "to deal with the jury's question about what happened to Harry's blood if anything" among other matters (p72),
Admitted and found proved

e. You told the court that a sample of blood had been taken at post mortem and when asked if you knew what had been done with that, said that it was submitted for toxicological examination and that some of it would have been sent for viral studies, to see if there was some viral infection,
Admitted and found proved

f. You did not tell the court that a sample of blood taken at post mortem had been subjected to blood culture and that enterococcus faecalis and coagulase negative staph had been isolated,
Admitted and found proved

g. You wrongfully failed and/or chose not to disclose the microbiology results,
Found proved
(The Panel found no evidence that you intended to mislead)

h. In the respects at heads 20.d., 20.e., 20.f. and 20.g. above, you failed to discharge your said duty as an expert witness;
Found proved
(Please see clarification under heads of charge 17 and 18)

'21. On or about 9 November 1999 Mrs Sally Clark was convicted by a majority of 10 to 2 of the murder of Christopher and Harry Clark;
Admitted and found proved

'22. a. In or about September 2002, you were asked by Leading Counsel for the Crown, in relation to an appeal by Mrs Sally Clark against her conviction the following questions (among others),

"Q4 Did Dr Williams take into account each of the reports listed above in reaching his conclusion and in preparing his post mortem report on Harry?

Q5 If so, why did Dr Williams make no specific mention of the microbiological reports in his post mortem report and his witness statement? What was his normal practice in referring to such results in post mortem reports?"
Admitted and found proved

b. By written answer dated 5 September 2002, you said,

"4 These reports were considered with the other post mortem findings in reaching my diagnosis.

5 It is not my practice to refer to additional results in my post mortem unless they are relevant to the cause of death, as the specimens were referred to another consultant, I regard them to be his results. In the same way I have not referred to the reports of Prof Green nor Dr Smith.",
Admitted and found proved

c. If your practice was as stated in your written answer to question 5, such practice was inconsistent with your duties as a pathologist,
Found proved
(***Please see clarification at head of charge 19. The Panel is satisfied that you had a duty to refer, in your post mortem reports, to the results that you have requested)***

d. If your practice was not as stated in such written answer, your written answer was misleading;
Found proved

'23. On or about 29 January 2003, upon appeal by Mrs Clark, the Court of Appeal concluded that Mrs Clark's convictions for murder were unsafe, allowed the appeal and quashed the convictions;'
Admitted and found proved

[I wish to emphasise, on behalf of The Panel, to the Complainant, to the Press and to the public that the Panel's determination is not concerned with why or how Christopher and Harry Clark died. This hearing is solely concerned with the allegations in the charge against Dr Alan Roy Williams, the forensic pathologist called by the Crown at the trial of Mrs Clark. At Mrs Clark's second appeal in 2002, her conviction was held to be unsafe. The Panel's findings of fact on those allegations were announced on May 27th this year and additional reasons for the findings of fact have been added to the full record, which is available to all]

Dr Williams:

1. The issues in this Hearing were complex. That there was much to be said on both sides, is reflected by the fact that the Panel heard evidence and submissions for six weeks.

2. The Panel comprised three doctors - a Consultant surgeon, a GP and a retired Professor of Medicine and two lay members - a retired Director of Social Services and a retired University College Principal. All are experienced Panellists and were aware of unusually strong views on this case on both sides.

3. The Panel has not been influenced in its judgement by the spectre of appeals either by you, on the grounds that the Panel has been too harsh, or by the Council for the Regulation of Health Professionals, on the grounds that it has been unduly lenient. It has, however, exceptionally and succinctly, set out reasons for its findings of fact as well as for its determination. The Panel has taken care to avoid reading press accounts of the case. Members have put from their minds any media references that have come to their notice.

4. Panel is required to judge your practice by the standards applicable in 1996-9. In considering its findings of fact, the Panel has taken care to avoid judgement by hindsight; making you, as one expert put it, "a scapegoat with the benefit of hindsight". The Panel is aware that practice in this field has moved on.

5. Panel's principle concern is whether you showed reasonable competence and care in making and recording the detailed description of your post mortem findings, and had offered conclusions, which not only interpreted your findings but also permitted others, in accordance with the Home Office Guidelines for Forensic Pathologists, to question your interpretation.

6. The Panel was therefore not primarily concerned with whether, taken individually, observations and inferences were correct. Indeed, the Panel was made aware that some of the other experts involved also made errors and that, in any event, there were, and, to some extent, still are, legitimate differences of opinion about the post-mortem findings and their significance in relation to the deaths of both Christopher and Harry Clark. As one of the experts put it to the Panel, "difference of opinion is part of our working lives".

7. Furthermore, at the very heart of the case was the need for you, yourself, to recognize and to communicate to others, the degree of certainty

or uncertainty underlying your interpretation of pathological findings at post mortem examination of Christopher and Harry Clark.

8. The Panel heard evidence from Dr Anscombe and Dr Armour, experts called respectively by the Complainant and in your defence, that in a murder trial, the pathologist with an overview of the whole case, namely the pathologist retained by the Crown, has a clear, predictable and heavy professional responsibility to ensure the disclosure of all evidence, which might conceivably assist the defence. That responsibility was described as an "absolute" by Dr Anscombe.

9. With respect to your post mortem examination of Christopher Clark in 1996, the Panel found that you had failed to exercise reasonable care and skill in interpreting and reporting on the lungs and spleen. Your report also failed to discuss the possible significance of your findings of bruises and torn frenulum, injuries which raised the possibility of unnatural death.

10. In giving as the cause of death,"lower respiratory tract infection", you failed to indicate how slender was the evidence on which it was based. It was so slender that, after the death of Harry, you abandoned it altogether as a sufficient cause of death. You then, having abandoned the significance of your finding at trial, defended it before the Panel. All the experts who gave evidence before the Panel, including Dr Armour, would have given the cause of death as "unascertained", although Dr Armour considered your diagnosis to have been "within the reasonable spectrum of medical opinion". Dr Anscombe said there was no microscopical confirmation of lung infection. The Panel were shown the slides; it viewed the slides not as experts, but used them as an aid to their understanding of the expert evidence. It concluded that there was, at most, minimal evidence of acute infection, and certainly insufficient evidence of acute lung infection, as the cause of death. As the Legal Assessor advised, it is the Panel's responsibility, when experts disagree, having carefully considered all the evidence, to decide which opinion, if any, to accept when reaching its conclusions.

11. Dr Armour and Dr Anscombe were of the opinion that you should have discussed Christopher's injuries in your report, irrespective of the outcome of any police investigation. Overall, the Panel concluded that you failed to express fair, objective and accurate opinions in your report, in your written statement and in your oral evidence relating to Christopher Clark. The effect was that your postmortem consideration and treatment of Christopher Clark impaired the reliable evaluation of the cause of his death.

12. In the January 1998 post mortem report on Harry Clark, you attributed death to shaking, although all the key evidence (intra-retinal haemorrhage, contusional tears in the brain, subdural spinal haemorrhage and acute inflammation and bruising of paraspinal muscles) could not be sustained. Some other experts initially agreed with some of your findings but you alone were mistaken in respect of all these key findings. Counsel submitted on your behalf that these were all understandable mistakes. The Panel concluded that, in the circumstances of a criminal trial, even if "understandable", these were, taken together, like chalk and cheese.

13. Your report made no mention of the biochemical and microbiological tests you had commissioned on Harry's cerebro-spinal fluid and no results were given. The microbiological findings were described by Dr Wills, the Consultant microbiologist, as "somewhat unusual" and by Dr Anscombe as "very unusual". The results were sufficiently unusual, in any event, for further tests to be done in an attempt to understand the significance of pure cultures of Staphylococcus aureus. Dr Armour and Dr Anscombe were of the opinion that failing to mention those tests at all fell below an acceptable standard, although neither of them, nor most of the other experts, in fact considered that those results indicated the cause of Harry's death. Professor Morris, however, considered the findings highly material.

14. The relevance of those microbiology tests would properly have been canvassed in court. Indeed, in evidence to the Panel, you agreed that those test results might possibly have assisted the Defence. Whatever your own views, even if reasonable, you had a responsibility as an experienced forensic pathologist to consider whether test results might need to be openly discussed, before being discounted, in order to prevent any risk of a miscarriage of justice.

15. It is clear to the Panel that during the period leading up to trial, the other experts involved in the case would have relied on you, in what they considered to be the normal way, to bring to their attention any investigation results which might possibly be relevant. They took the absence of any results to mean that any routine investigations not included in your report, were, without question, entirely negative. There were a number of opportunities, in your reports, at the committal Hearing, in the run-up to the criminal trial and in the course of the trial itself, for you to have referred to the test results.

16. You told the Panel that if experts for the Defence wished to have results for tests you considered not to be relevant, they should have asked for them; or that the Police gathering of records should have ensured that the microbiology results were available before the trial. The Panel was satisfied that you had an overriding responsibility to record those findings in your report. Your responsibility as the pathologist with an overview of the whole case was to state and progressively review the facts or assumptions on which your opinions were based. You should not have omitted mention of findings which might detract from your considered opinion, for which, by the time of the trial, there was diminishing evidence.

17. The Panel found that with respect to Harry Clark, your post mortem consideration and treatment was such that it impaired the reliable evaluation of his cause of death. It also found that in failing to disclose Harry's post mortem microbiology results, you failed to discharge your duty as an expert witness. It further found that, in your capacity as an expert witness retained by the Crown, you were under a duty to share the fact and arguable significance of the microbiology and biochemistry reports. You were wrong not to do so. Nor does the Panel accept that, as the results were set out in Dr Wills' report, that it was for him, not you, to disclose them. You commissioned the tests and the reports came to you.

18. You, a general pathologist, knowingly accepted the highest level of forensic paediatric responsibility: first, in respect of Christopher, where your involvement of the Police recognized the possibility of unnatural death; second, with respect to Harry, for whom unnatural death was an even stronger possibility from the outset. You put yourself in the position where you might have a pivotal role in a criminal trial.

19. You therefore had clear obligations from the outset to follow the stringent Home Office Recommendations and Guidelines, 1996. If you disregarded them, it was not only at your peril, but also at the peril of Mrs Clark. High standards were neither an option nor an "ivory tower" mirage, but your obligation:.A fair trial hinged on your evidence. As Dr Anscombe said, in evidence to the Panel, "for a forensic pathologist in a murder case simply being honest is not sufficient", a view echoed by your Counsel in his closing submission when he said, "Best of one's ability is not enough in this sort of case". It is not enough now, and it was not enough then. You have to be judged, not as a general pathologist but as a competent forensic pathologist, undertaking complex paediatric cases of this nature.

20. The Panel does not accept, as mitigation relevant to the gravity of your actions in these two cases, that the QASS Policy Advisory Board for forensic pathologists, as late as 2002, had continuing concerns about the quality of reports by forensic pathologists. You alone were responsible for your actions and their predictable consequences in respect to a fair trial. The Panel considered the parallel, drawn by your Counsel, to the Privy Council judgment of *Dr Silver* (Appeal No. of 66 of 2002), in which the finding of serious professional misconduct was set aside, partly because the misconduct related to an isolated incident in an otherwise unblemished career. The Panel found that the catalogue of your uncorrected errors of observation and judgement over a three year period, could not properly be so regarded. However, even if a parallel could be drawn, the seriousness of the predictable impact of your misconduct could not be disregarded.

21. Taking account of the judgment in the Court of Appeal in the case of *Campbell v GMC* (EWCA Civ 250/2005) and the advice of the Legal Assessor, the Panel also does not accept that the general testimonials to your normally good standards of work as a pathologist are mitigation relevant to whether your conduct in the specific circumstances of the deaths of Christopher and Harry Clark amounted to serious professional misconduct. It found nothing in the circumstances in which you were working at the time, to downgrade the seriousness of your conduct.

22. Your errors and omissions were formidable. Taken collectively as the setting in which your misconduct has to be assessed, the Panel is sure that your errors and omissions seriously undermined confidence in the role of a doctor as an expert witness. The Panel accordingly find you guilty of Serious Professional Misconduct.

23. The Panel found no evidence of calculated or wilful failure to disclose results of tests, no malice, and no intention to mislead. It concluded that you

were either working beyond your competence (which is specifically condemned in Good Medical Practice) or you were culpably careless, or both.

24. Having made a finding of serious professional misconduct the Panel considered what sanction, if any, should be imposed on your registration. The Panel members have considered the GMC's Indicative Sanctions Guidance, but at the end of the day, they have used their own judgement in reaching their decisions.

25. [I should explain on behalf of the Panel, to the press and public, that sanctions may be imposed on a doctor's registration for three reasons: first, to protect patients; second to maintain public confidence in the profession and third, to declare and uphold proper standards of conduct. Sanctions may of course have a punitive effect but punishment is not the Panel's remit.]

26. The lowest level of sanction, a reprimand, fails in this case either to reflect the seriousness of your undermining of public confidence in doctors who have a pivotal role in the criminal justice system or to address unresolved concerns about your competence as a forensic pathologist.

27. The next option is the imposition of conditions on your registration. Looking at the Guidance, the Panel notes that, in the light of the findings on your conduct, the following criteria are met:

- No evidence has been adduced of "harmful deep seated or attitudinal problems"; there is no evidence of calculated or wilful intention to mislead
- There is no evidence of general incompetence, indeed the reverse obtains: impressive testimonials indicate your skills as a general pathologist are highly respected and valued; these skills are nationally, and locally, in short supply.
- There is no suggestion that you are a "danger to patients".
- It would be "possible to devise practical conditions" to ensure that any concerns about your competence as a forensic pathologist are addressed.

28. On the other hand, the Panel considered carefully and at length, whether the imposition of conditions on your registration would be sufficient to mark the seriousness of your misconduct: sufficient to maintain public confidence in the role of doctors in the criminal justice system, or sufficient to send a clear signal to the profession about the need to uphold standards in forensic pathology. Both suspension and erasure, for which the Complainant had pressed, were considered.

29. The Panel took into account, several sources of mitigation:

- the impressive oral evidence and written testimonials from professional colleagues to the high quality of your work as a general pathologist
- several medical experts also made errors in this case
- there was no evidence of your wilfully withholding evidence
- failures on the system of collecting records by the Police

- no other issues have previously been raised against you, and,
- evidence adduced during this hearing that forensic pathology has already taken the lessons of this case profoundly to heart.

30. Furthermore, the Panel was mindful that there is clear judicial authority from the Privy Council (*Bijl v GMC,Appeal No. 78 of 2000*) that it should not carry its concern for public confidence in the profession and its procedures for dealing with doctors who lapse from professional standards "to the extent of feeling it necessary to sacrifice the career of an otherwise competent and useful doctor who presents no danger to the public, in order to satisfy a demand for blame and punishment". As I have already explained, punishment is not the remit of this Panel. There is no evidence that as a general pathologist you are unsafe, indeed, your skills are both needed and valued.

31. The finding of serious professional misconduct is a serious blow to any doctor. To prevent you practising as a forensic pathologist would be an even greater blow. The only way in which the Panel can prevent you undertaking forensic pathology while allowing you to continue to practise as a general pathologist is by the imposition of conditions on your registration. Taking account of the material facts found proved against you, the mitigation and the need for proportionality, the Panel has determined that the fairest and most effective way to uphold standards and maintain public confidence in the role of doctors in the Criminal Justice System, is by, in effect, banning you from forensic pathology.

32. Your registration will be subject to the following condition for a period of three years, the maximum that the Panel is able to impose:

1. You shall not undertake any Home Office pathology or Coroners' cases.

33. The reason for the restriction on Coroners' cases is because of the potential overlap between the two jurisdictions of the Coroner and the Home Office, as illustrated by the post mortem of Christopher Clark.

34. You will return to the Panel before the end of that period for further consideration as to whether that condition should be continued. Among the papers a Panel would expect to see at a resumed Hearing would be evidence that you have kept your medical skills up-to-date, and testimonials as to your conduct since this Hearing.

35. The message which the Panel sends to the public and to the profession is this: where justice depends on a doctor, neither competence nor care can be compromised.

36. Unless you appeal the effect of this direction is that your registration will become subject to the above condition in 28 days time. If you do appeal, your current status as a fully registered practitioner will remain in force until such time as the appeal is decided.

The Panel cannot conclude without drawing attention to the cogent criticisms expressed by expert witnesses during this Hearing, of the lack of support and career structure in England and Wales, for forensic pathology by the Home Office, the NHS and the Universities. One expert witness referred to forensic pathologists as "a wandering band of gypsies."