Neutral Citation Number: [2024] EWHC 1663 (Admin)

Case No: AC-2O23-LON-003193

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

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 2nd July 2024

Before :

DHCJ Dexter Dias KC

- -

Between :

DR DAVID COOK — **Appellant**

- and –

GENERAL MEDICAL COUNCIL — **Respondent**

- -
- -

Vivienne Tanchel (instructed by **Weightmans**) for the **Appellant**
Heather Emmerson (instructed by **General Medical Council**) for the **Respondent**

Hearing dates: 30th April 2024

- -

Approved Judgment

This judgment was handed down remotely at 10.30am on 2nd July 2024 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

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DEXTER DIAS KC SITTING AS A DEPUTY JUDGE OF THE HIGH COURT

DHCJ Dexter Dias KC:

1. This is the judgment of the court.

2. To assist the parties and the public follow the court's line of reasoning, the text is divided into eight sections, as set out in the table below.

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B123: hearing bundle page number.

References to the appellant's skeleton argument are to the document dated 8 December 2023. References to the "Addendum Skeleton" dated 21 April 2024 are marked "Skeleton 2".

§I. INTRODUCTION

3. This is an application under s.41A(10) of the Medical Act 1983 ("the Act") for the court to revoke an order of the Interim Orders Tribunal ("the IOT"), an independent statutory tribunal that considers interim restrictions on registration and the suspensions of doctors from medical practice. In September 2023, the IOT imposed conditions on a senior respiratory consultant which significantly restrict his ability to practice medicine. The IOT maintained the conditions in March 2024. The consultant is Dr David Cook. Dr Cook had engaged in online discussions about meeting an 8-year-old child to sexually abuse her.

4. Following a trial in the Crown Court, the jury convicted Dr Cook of two criminal offences:

    (1) Publishing obscene material contrary to s.2(1) of the Obscene Publications Act 1959;

    (2) An attempt to do the same, contrary to the Criminal Attempts Act 1981.

5. The child in question did not exist as, unbeknownst to him, Dr Cook was in fact discussing sexually abusing children with an undercover police officer.

6. While Dr Cook accepts that there should be conditions restricting his return to medical practice, there are two conditions imposed by the IOT that he objects to. They are a condition that he is clinically supervised by a senior practitioner on his return to treating patients, and that he should not take up any locum posts of fewer than 8 weeks' duration. He "appeals" against the IOT's imposition and continuation of these two conditions and seeks their revocation under s.41A(10) of the Act. This statutory provision empowers the High Court as a "relevant court" to "vary" or "revoke" conditions imposed by the IOT.

7. In this hearing, therefore, Dr Cook is the appellant. He is represented by Ms Tanchel of counsel. The respondent is the General Medical Council ("GMC"). The respondent is represented by Ms Emmerson of counsel. The court is grateful to counsel for their submissions. While the background is complicated, what is immediately in dispute can be stated shortly, before a more detailed exposition is provided in Section V of the judgment.

8. On 11 August 2023, the IOT imposed conditions on Dr Cook's registration. However, these did not include any conditions of clinical supervision or restriction on minimum length of locum posting. On 27 September 2023 there was a further review by the IOT. By this point, the Tribunal had received two independent expert health reports from consultant psychiatrists. While the IOT decided to continue a Conditions of Practice Order imposed on Dr Cook, which he does not dispute in principle, the IOT added two further conditions:

   (1) a condition of clinical supervision ("**challenged condition 1**");

   (2) a prohibition on Dr Cook taking up a locum post of fewer than 8 weeks' duration ("**challenged condition 2**").

9. These conditions were maintained at a further hearing before the IOT on 15 March 2024. His challenge under the Act is against these two conditions, and submits that the court should exercise its discretion to revoke them.

§II. LEGAL FRAMEWORK

10. The applicable law can be stated shortly. It is important to note that Dr Cook's challenge is not by way of judicial review. Instead, he invites the court to exercise its jurisdiction under s.41A(10)(b) of the Act. That statutory provision confers original powers on the court, as Arden LJ explained in *GMC v Hiew* [2007] 1 WLR 2007 at [27]. Section 41A(10) provides insofar as it is material:

> "(10) Where an order has effect under any provision of this section, the relevant court may—
>
> …
>
> (b) in the case of an order for interim conditional registration, revoke or vary any condition imposed by the order;
>
> …

> and the decision of the relevant court under any application under this subsection shall be final."

11. However, the Tribunal's decision will remain intact and undisturbed unless the court determines that it is "wrong" (*Sandler v GMC* [2010] EWHC 1029 (Admin) at [12], per Nicol J ("*Sandler*")). Thus, this is not an unrestricted merits appeal since the task of this court is tempered by affording special weight to the decision of the Tribunal below.

12. This is because the High Court has historically recognised that it is being asked to overturn the decision of a specialist disciplinary panel, which is ordinarily entitled to be afforded considerable respect (*Harry v GMC* [2012] EWHC 2762 (QB) at [2], per Burnett J (as he then was)). The test this court must apply may be formulated in different ways:

> Whether the court should exercise its discretion ("may" vary/revoke) differently to the Tribunal, while affording the expert tribunal's decision due respect;
>
> or
>
> Determining what is the "appropriate" order in the case, a matter for this court to determine itself on all the evidence now available to it, again respecting but not being subservient to the Tribunal's decision, and only disturbing it if it is wrong.

13. There is no material difference between these formulations. What does "wrong" mean? The Court of Appeal recently provided assistance in *Waltham Forest LBC v Hussain & Ors* [2023] EWCA (Civ) 733 at [64] ("*Hussain*"):

> " 'Wrong', as Upper Tribunal Judge Cooke explained in *Marshall v Waltham Forest LBC* [2020] UKUT 35 (LC) . . . means in this context that the appellate tribunal disagrees with the original decision despite having accorded it the deference (or 'special weight') appropriate to a decision involving the exercise of judgment by the body tasked by Parliament with the primary responsibility for making licensing decisions. It does not mean 'wrong in law' [what amounts to a species of judicial review challenge]. Put simply, the question that the FTT must address is, does the Tribunal consider that the authority should have decided the application differently?"

14. The fact that *Hussain* dealt with a different statutory context is neither here nor there: conceptually the issues are identical. The point of – and I would add public interest in - showing respect to the Tribunal's decision is that this is an independent statutory panel that has and is assumed to have expertise in "issues of public perception and public confidence" in the medical profession (*R (Sheik) v General Dental Council* [2007] EWHC 2972 (Admin) at [34], per Davis J). In *Howells v GMC* [2015] EWHC 348 (Admin) ("*Howells*"), Laing J (as she then was) said at [35] that "The panel is an expert body which is in a better position to assess the requirements of the profession and issues of public perception and of public confidence than is the court." Such a body has been authorised by Parliament to take the prime responsibility for making certain important decisions about the regulation of doctors. This is separate to the prime statutory duty of the GMC, which has its multifaceted protective duty also conferred by statute (the Act, s.1(1B)):

> "(a) to protect, promote and maintain the health, safety and well-being of the public,
>
> (b) to promote and maintain public confidence in the medical profession, and
>
> (c) to promote and maintain proper professional standards and conduct for members of that profession."

15. The degree of weight afforded to the Tribunal's decision is not fixed. It depends on context and the intrinsic cogency of the original decision. As explained by Sharp LJ in *GMC v Jagjivan* [2017] 1 WLR 4438 at [40]:

> "(v) In regulatory proceedings the appellate court will not have the professional expertise of the Tribunal of fact. As a consequence, the appellate court will approach Tribunal determinations about whether conduct is serious misconduct or impairs a person's fitness to practise, and what is necessary to maintain public confidence and proper standards in the profession and sanctions, with diffidence: see *Fatnani* at paragraph 16; and *Khan v General Pharmaceutical Council* [2016] UKSC 64; [2017] 1 WLR 169, at paragraph 36.
>
> (vi) However there may be matters, such as dishonesty or sexual misconduct, where the court 'is likely to feel that it can assess what is needed to protect the public or maintain the reputation of the profession more easily for itself and thus attach less weight to the expertise of the Tribunal …': see *Council for the Regulation of Healthcare Professionals v GMC and Southall* [2005] EWHC 579 (Admin); [2005] Lloyd's Rep Med 365 at paragraph 11, and *Khan* at paragraph 36(c). As Lord Millett observed in *Ghosh v GMC* [2001] UKPC 29; [2001] 1 WLR 1915 and 1923G, the appellate court 'will afford an appropriate measure of respect of the judgment in the committee … but the [appellate court] will not defer to the committee's judgment more than is warranted by the circumstances'."

16. Plainly, the formulation "more than warranted" implies an evaluation by this court of both the context and the merits of the challenged decision. Of pertinence in this challenge is the test for the imposition of conditions on a doctor's practice. It is set out in the Previous Guidance and Current Guidance at §27. This states:

> ".. the IOT should make the appropriate order if it is satisfied that:
>
> a. In all the circumstances that there may be impairment of the doctor's fitness to practise which poses a real risk to members of the public **["Subclause 1"]**, or may adversely affect the public interest or the interests of the doctor **["Subclause 2"]**;
>
> and
>
> b. after balancing the interest of the doctor and the interests of the public, that an interim order is necessary to guard against such risk".

17. It will be noted that in paragraph a., two different tests have been identified on either side of the comma. Subclause 1 (my label) is in essence a public safety test ("real risk"). Subclause 2 is concerned with "interests", those of the public and the doctor. These two bases for the imposition of restrictions on a doctor's practice were the source of much forensic contestation before the court.

18. The importance of this court's decision is heightened by the fact that its decision is "final", as s.41A(10) makes plain. There is no further appeal or challenge. Therefore, the court is acutely aware that both parties seek a decision in their favour that the other side cannot overturn or disturb. The court reserved judgment to reflect carefully on the rival arguments that were advanced by both counsel with conspicuous skill and focus.

§III. GROUNDS

19. Dr Cook seeks the termination of the two conditions on the following nine grounds of challenge:

> **Ground 1** – the conditions are not necessary for the protection of the public, nor is it in the public interest for Dr Cook's practice to be supervised.
>
> **Ground 2** – the IOT failed to take into account relevant matters.
>
> **Ground 3** – there was a failure to follow IOT Guidance requiring a "real risk" to a member of the public.
>
> **Ground 4** – the clinical supervision condition is disproportionate.
>
> **Ground 5 and 6** – there was a failure to provide Dr Cook with the opportunity to address the IOT on relevant matters.
>
> **Ground 7** – the IOT failed to provide adequate reasoning as to which of Dr Cook's interests it had considered and how the public interest outweighed them.
>
> **Ground 8** – the IOT's decision is not supported by the facts, circumstances, and evidence and therefore is manifestly disproportionate.
>
> **Ground 9** – The IOT erred in its March 2024 decision in requiring Dr Cook to prove that the order is disproportionate [the criticism being that the Tribunal "reversed" the burden of proof].

§IV. APPROACH

20. I must set out the court's approach and explain what it will and will not do. Two initial observations need to be made.

21. First, as will be immediately apparent, there is a measure of overlap between the grounds. Second, and connected to the first point, as this is not a judicial review, the court is tasked under the Act to examine the case as a whole and assess whether the disputed conditions are justified and appropriate or have been wrongly imposed on Dr Cook. What is essential is to look at the substance of the case and the appropriateness of the conditions on all the evidence as the case stands before the court now in order to decide whether the conditions should be varied or revoked. The court has no jurisdiction, for example, to "quash" a previous decision equivalent to judicial review

relief. Instead, it may terminate an order or part of it (for example, one condition out of several) if it deems it inappropriate or wrong.

22. A point arose about what decision or decisions of the Tribunal the High Court was exercising its jurisdiction over (see Skeleton 2 generally). The appellant argued that the court should consider first the September 2023 decision of the Tribunal, assess whether it was appropriate or "wrong", and only if it stands should the court go on to consider the Tribunal's decision in March 2024, arguing "should the court remove the September conditions, then the March conditions must fall." I am unconvinced that this is the right approach. While this court may terminate extant conditions, it is not its function in a judicial review-like fashion to retrospectively quash previous decisions that have been superseded. This point was made in *General Medical Council v Sheill* [2006] EWHC 3025 (Admin) at [25] ("*Sheill*"), per Crane J:

> "As was pointed out in *Madan*, the court has power under section 41A(10) to terminate suspension, but not to quash the order made. The court's order will not affect the period of suspension already passed."

23. At [30], the Judge concluded that "the court will not necessarily reconsider the correctness of the original order." Further support for this approach is found in *Howells* at [40]:

> "There are three preliminary points. First, Miss White for the GMC submitted that I should concentrate on the most recent order of the IOP made on 27 October 2014 and that for the purposes of this hearing the earlier orders and the matters which the IOP took into account in making those orders are, as it were, water under the bridge. I accept that submission."

24. However, the court concurs with the submission made on behalf of Dr Cook that he filed his appeal against the September 2023 order in good time. It was only because of a listing impossibility that he was unable to make his argument in court before the March 2024 review. However, events have procedurally overtaken his timely challenge. The September 2023 order was reviewed by the Tribunal in March 2024. The court considers that the approach in *Sheill* and *Howells* is undoubtedly correct. Therefore, the focus is on whether the Tribunal's decision in March 2024 maintaining the two challenged conditions is appropriate. It is not this court's task in a non-judicial review case to consider quashing an order that has itself been superseded by the disciplinary tribunal seized with its review. I would add that nonetheless there is no significant difference of substance between the September and March decisions and the questions of proportionality and appropriateness that arise are virtually identical. The principal difference is that by March 2024 there were further written submissions made on behalf of Dr Cook outlining difficulties he had experienced with obtaining locum posts. I will deal with this material in due course.

25. The court will consider the clinical supervision condition first, and then the locum-length condition, but first fleshes out the facts in more detail while also providing a procedural history.

§V. FACTS AND PROCEDURAL HISTORY

26. Dr Cook was arrested by the West Midlands Police on 21 May 2021. On 22 May, he emailed the GMC notifying it of his arrest. The arrest was on suspicion of offences under s.9 of the Sexual Offences Act 2003 relating to sexual activity with a child under the age of 13. This was as a result of conversations the appellant had engaged in on various internet and remote platforms.

27. Dr Cook had taken an active part in online discussions with a man who purported to be the parent of a young child. Dr Cook called himself "David" and said he worked in the public sector and had been "swinging for a while". He was looking for a "regular [sexual] thing" with a couple or family. He was told that the family in question had a female child under the age of 16 and he was asked if that was "an issue". Dr Cook replied, "Not at all - never been an issue in the families I've seen before." Dr Cook added, "I think there's a lot of people with porn-based rape fantasies about, I genuinely prefer younger girls/families who enjoy this and want this." Dr Cook said, "8 is the youngest [child] I've seen/been involved with." Dr Cook's correspondent confirmed that his family's child was also aged 8. In response, Dr Cook said, "I don't mind being watched whilst just me and her, with families that's often how it goes anyway!"

28. After a break, the conversations continued. Dr Cook said, "I'd imagine having the night with her would be wonderful." He described a child from previous sexual encounters he had taken part in as being "Very open as she'd obviously been active before – it's not like she was new to it, she was [description of two sexual acts with him] very quickly to be fair – didn't have to really encourage anything it just happened naturally."

29. He said he could "train" his correspondent's child sexually and that, "It's a wonderful experience." He said that after he trains the child, the child cannot stop having sex and asks for it. Dr Cook said that maybe the father and Dr Cook could take the child to a hotel to have sex with her there. Dr Cook said that sex with the child would be "amazing".

30. Thus, David Cook discussed sexually abusing children and arrangements were explored to meet and sexually abuse the female child that he was told was aged 8. The discussions involved the rape, both oral and vaginal, of children and the method that could be adopted for Dr Cook to gain the trust of the female child so he could "train" her for the purposes of being sexually abused by him. Dr Cook stated that he had previously sexually abused children. There were detailed discussions about where and when Dr Cook could meet the father and his daughter. Dr Cook had no idea he was in fact discussing these matters with an undercover police officer. On arrest, Dr Cook stated that he was engaging in fantasy role-playing and in truth he had no sexual interest in children.

31. On 8 June 2021, the West Midlands Police emailed the GMC detailing the charges that Dr Cook was under investigation for.

32. On 28 June 2021, the IOT imposed an order of conditions, restricting Dr Cook's ability to practice medicine for 18 months. The imposition of the order was not disputed by the appellant. The rationale for the decision was:

> ". . . the serious nature of the concerns raised about Dr Cook's conduct involving the ongoing police investigation into allegations of sexual offences against a child under 13 years of age."

33. When Dr Cook was interviewed by the police on 1 July 2021, he stated he had been suffering from mental health issues. He accepted that he had not, as he had claimed, "book[ed] himself" into a psychiatric unit, but had been admitted to the Queen Elizabeth Hospital by a consultant because of his mental health.

34. On 2 July 2021, Dr Cook was charged with four offences connected to the sexual abuse of children or the publishing of obscene sexual material about them. The first count related to Dr Cook discussing sexual abuse with the child's father and the father speaking to the daughter about the possibility of her taking part in penetrative sexual activity with another man, who was Dr Cook. The second count related to the conversations Dr Cook had with the 8 year-old's father about making arrangements so that Dr Cook could sexually abuse her in this way. Counts 3 and 4 related to the publication on the internet of these "obscene" communications ("articles"). They were obscene because they were discussions about child sexual abuse, including lurid details of the sexual acts and the child's response to being sexually abused and being groomed for sex.

35. Dr Cook's wider claims during his conversations about the "other children" he had abused are consistent with information found on his devices that the police seized. On one of the chat platforms there were conversations from 2020-21 with someone purporting to be a female user. This person sent Dr Cook photographs of herself and her daughter, along with images of her nephew and niece. There were discussions with Dr Cook about meeting and sexually abusing these children. Dr Cook explained how he would sexually abuse the female child who was "nearly 8". He again suggested that the meeting could take place in a hotel. However, it must be emphasised that these conversations did not form part of the criminal indictment he faced in the Crown Court, but were part of the background documented in the police report and contained in the bundle provided to the IOT for the September 2023 hearing (B49-605).

36. On 5 August 2021, the IOT conducted an early review of the interim order for conditions due to the criminal charges and varied the order to one of interim suspension. The Tribunal determined that a reasonable member of the public would be shocked and concerned if no order was made given the serious nature of the criminal charges.

37. The order was continued on 14 October 2021, 29 March 2022 and 7 September 2022.

38. Dr Cook faced trial in September 2022. Evidence was presented on behalf of Dr Cook from a forensic psychiatrist Dr Dinesh Maganty (report dated 8 August 2022). Dr Maganty stated that over the previous years, Dr Cook had experienced a:

> "Worsening of his depressive illness (a mental disorder within the meaning of the Mental Health Act) with it reaching the severe end of the spectrum, with low mood, tiredness and impaired concentration."

However, Dr Maganty continued:

> "A direct correlation or causative link cannot necessarily be drawn between the actions of individuals such as Dr Cook, who was suffering with a depressive illness together with autism, and their online actions involving conversations and actual physical sexual assaults or violence. A good quality evidence that individuals who suffer with autism and severe depression who indulge in online conversations regarding sexual abuse going on to commit in person sexual violence does not exist."

39. Dr Maganty also reported that:

> "Dr David Cook would benefit from engaging in an internet specific sex offender treatment programme should he be found guilty. The continued treatment that he has received for his severe depressive episode, including inpatient care, has led to improvement in his mental health. He has also received cognitive behavioural therapy, which is likely to further improve his mental health in combination with his ongoing treatment pharmacologically. A combination of the above two would substantially reduce his risk of further offending online."

40. The jury could not reach a verdict on the charges (counts) under the Sexual Offences Act 2003 relating to arranging/facilitating the commission of child sex offences. Nevertheless, Dr Cook was convicted of two other criminal offences. They were:

> Count 3 – Attempting to/attempted publication of an obscene article namely an online conversation discussing the sexual abuse of an 8-year-old girl contrary to section 2(1) of the Obscene Publications Act 1959.
>
> Count 4 - Publishing an obscene article namely an online conversation discussing meeting up with an adult female in order to sexually abuse children under 13 contrary to section 2(1) of the Obscene Publications Act 1959.

41. The prosecution decided not to press for a retrial on the two counts upon which the jury could not decide. On 20 September 2022, the Crown Court imposed conditional discharges of 12 months for each criminal offence, taking into account Dr Cook's previous positive good character and that he had been suffering from "a severe mental illness".

42. On 28 November 2022, the High Court extended the interim suspension order to 27 December 2023, but on 10 March 2023, the IOT reviewed the case. It maintained Dr Cook's suspension. Dr Cook challenged the continuation of the suspension.

43. On 11 July 2023, Lane J concluded that the interim order of suspension should terminate on 17 August 2023 (*Cook v General Medical Council* [2023] EWHC 1906 (Admin)).

44. On 11 August 2023, the IOT substituted an interim order of conditions for the interim order of suspension. However, there were no health assessments available to the Tribunal at that point. It should be noted that in his judgment dated 13 July 2023, Lane J stated at [34], "I can see an advantage in the IOT having a medical assessment before it".

45. On 16 August 2023, the High Court extended the interim order of conditions until 17 August 2024.

46. Dr Cook underwent health assessments by two consultant psychiatrists. First by Dr David Reiss on 22 August 2023. The second by Dr Mayura Deshpande on 3 September 2023. Both diagnosed a recurrent depressive disorder and Asperger's Syndrome. Dr Reiss concluded that Dr Cook was most at risk of relapse if exposed to stressors such as stress at work. He recommended conditions on his practice to include a clinical supervisor and a workplace reporter and that these supervision requirements be extended to locum roles, including a requirement that his supervisor should be required to approve any locum roles. Dr Reiss's rationale for supervision included ensuring that Dr Cook performed his duties "to an appropriate standard."

47. Dr Deshpande recommended that Dr Cook be invited to either agree or have imposed on him a requirement for medical supervision. It was also recommended that Dr Cook have in place a workplace reporter and should continue to be overseen by Occupational Health of any employer. Dr Deshpande further suggested that any locum posts should be a matter for the Medical Supervisor.

48. Equipped with these assessments, the IOT reconsidered the case on 27 September 2023 in an early review. Therefore, while Dr Reiss recommended clinical supervision, Dr Deshpande was silent on the point. The Tribunal concluded that Dr Cook was fit to resume medical practice but subject to conditions. It stated:

> "Given the absence of concerns about clinical practice, the Tribunal determined that conditions requiring close or direct clinical supervision would not be appropriate or proportionate. The Tribunal recognised, however, that Dr Cook had been away from clinical practice for some time. For these reasons, and having considered Dr Reiss' recommendation, the Tribunal determined that the lightest level of clinical supervision would be appropriate."

49. In light of the newly available health assessments, the Tribunal imposed two additional conditions. The clinical supervision was the "lightest" form of such supervision, requiring a fortnightly meeting with a duly qualified senior practitioner. The conditions imposed were formulated in this way:

> Condition 5 – Dr Cook to be supervised in all his posts by a clinical supervisor, who is appointed by his responsible officer. The role of the supervisor is limited to (i) taking overall responsibility for the arrangements for the doctor's supervision, which in practice means being available for advice or assistance and (ii) meeting with the doctor formally, in person, at least once a fortnight for a case-based discussion.
>
> Condition 6 – Dr Cook must not work in any locum or fixed term contract of less than 8 weeks duration.

50. A challenge to ("appeal" against) these two conditions was filed by the appellant on 25 October 2023.

51. As noted, the appellate hearing could not be listed before the IOT itself undertook a review of its September 2023 decision, in line with the requirements of the statutory

provisions. The IOT's review took place on 15 March 2024. Dr Cook and his representatives did not attend, but written submissions were filed on his behalf. Dr Cook was notified of the result of the review on 18 March. The submissions filed on behalf of Dr Cook included that he had been unable to find locum work with employers (health trusts) being unwilling to engage him due to the existing conditions. The conclusion of the Tribunal was:

> "13. In reaching its decision, the Tribunal has borne in mind the serious sexual misconduct allegations raised, the subsequent criminal proceedings and conditional discharge. The Tribunal noted the health concerns and the GMC health assessors' opinion that Dr Cook was fit to practice with restrictions. The Tribunal noted the written submissions provided by Dr Cook's representatives, in particular the difficulties expressed about Dr Cook not being able to gain employment. The Tribunal was satisfied that public confidence in the profession may be seriously undermined if no order were made today, pending the outcome of the GMC investigation. The Tribunal also considered that an interim order was required in Dr Cook's own interests, given the health concerns raised.
>
> 14. The Tribunal considered whether the current conditions could be varied, however it was of the view that there was a lack of specific information before it today as to the reasons behind Dr Cook's difficulties in obtaining employment. The Tribunal considers that a variation of the conditions is therefore not warranted at this stage.
>
> 15. Whilst the Tribunal notes that the order has restricted Dr Cook's ability to practice medicine it is satisfied that the order imposed is the proportionate response. The Tribunal is satisfied that the current conditions remain sufficient as a measurable, workable and enforceable means of addressing the risks identified in this case."

52. The rival arguments in respect of each of the two challenged conditions will be set out in turn, with the court providing its analysis in a "discussion" subsection thereafter.

§VI. CHALLENGED CONDITION 1: CLINICAL SUPERVISION

53. On behalf of Dr Cook, it is submitted that it is not necessary for the protection of members of the public, nor in the public interest (whether those two elements are viewed cumulatively or separately) to require that the appellant's practice be supervised. Such clinical supervision is unnecessary and disproportionate when there has been no evidence adduced about Dr Cook's lack of clinical skills. The purpose of clinical supervision is to protect the public from practitioners whose professional performance creates a risk of harm. Here, there has been no concern about the level of medical care Dr Cook has provided patients. The fortnightly meeting with a clinical supervisor must be with a medical practitioner of comparable stature to be meaningful. It would need to be with a fellow respiratory consultant, who will write a report to the GMC. This is both difficult to arrange and pointless given the lack of concern. Dr Reiss who makes the recommendation for a clinical supervision condition bases it on the appellant's ill health, but Dr Reiss is not a respiratory expert.

54. Therefore, clinical supervision cannot assist with assessing Dr Cook's health problems. By contrast, Dr Deshpande does not make any recommendation for clinical supervision, and her silence on the question is vital. If she had felt it was indicated in Dr Cook's case, the court can assume that she would have made the recommendation. She did not. At the August 2023 hearing, the IOT did not consider clinical supervision was necessary, even though, as the appellant submits (Skeleton, §54) "consideration was given to a requirement for supervision of Dr Cook's practice and this was rejected by the Tribunal."

55. On behalf of the respondent, it is submitted that the condition of clinical supervision far from being disproportionate, was on the evidence necessary. The Tribunal was entitled to rely upon Dr Reiss's recommendation. The lack of clinical supervision recommendation by Dr Deshpande does not assist the appellant. The Tribunal did not reach its decision because of public safety, but because of the public interest and the interests of Dr Cook himself. This is not a "deskilling" case, but one tied to the concerns about the appellant's mental health.

Discussion: Clinical supervision

56. On behalf of Dr Cook, it is conceded that his behaviour in his private life has been "deeply unattractive". It is more than that. It has been criminal. His conduct has involved actions that resulted in him being convicted of criminal offences relating to the publication of obscene material about the sexual abuse of children. Due to the circumstances, no child has been harmed. Dr Cook says it was "fantasy" and "role-playing". The fantasy involved having detailed, graphic and disturbing conversations about having sex with an 8-year-old child, including further conversations about having oral, vaginal and anal sex with children. Dr Cook claimed to have sexually abused the children of other families.

57. Dr Cook's argument that the Tribunal proceeded on an erroneous basis and sought to impose a "real risk" or "public protection" test is wrong (**Ground 1**). The appellant submits (Skeleton §56) that "the underlying allegations in this case do not relate to Dr Cook's clinical practice." However, this misses the prime point that the concerns are around the appellant's mental health deterioration due to workplace stress. The expert evidence presented on his behalf at his criminal trial identified the link between his stressors and his criminal offending via a mental health deterioration. A proper reading of the Tribunal's decision clearly indicates that it imposed the challenged conditions on the basis of the second clause of the empowering provision (Subclause 2), the public interest basis and the interests of Dr Cook (by providing him with relevant professional support). Moreover, it is conceded on behalf of Dr Cook that it is legitimate in principle to impose a condition of clinical supervision in the public interest. It is difficult to conceive how it could be credibly argued otherwise. Paragraph 44 of the Previous and Current Guidance states:

> "where the IOT considers it appropriate to make an order for interim conditions, these may include conditions relating to the ongoing treatment and supervision of the doctor"

58. Dr Cook continues to take medication prescribed due to his mental health difficulties, and Dr Deshpande recommended that he remain in the care of his GP. When the IOT did not impose a clinical supervision condition in August 2023, it lacked the expert evidence to make the decision. Lane J in his July 2023 judgment identified the "advantage" there would be in having an expert health assessment. As of August 2023, it was unavailable. Two expert health assessments were available by the September 2023 hearing when the two challenged conditions were imposed. Therefore, at this point the Tribunal had the benefit of the reports of Dr Reiss and Dr Deshpande.

59. The appellant criticises the Tribunal for not explaining why it preferred Dr Reiss's report to that of Dr Deshpande. Two points may immediately be made about this. First, the function of this court is to assess what is the appropriate order, not to perform a judicial review of the Tribunal's decision. Second, the tenor of the appellant's submission is that by her silence, Dr Deshpande has determined that a condition of clinical supervision is unnecessary. This goes too far. At no point does Dr Deshpande state in terms that clinical supervision is unnecessary in Dr Cook's case. It is important to note what Dr Deshpande in fact said in her report (B538):

> "However, he remains vulnerable to relapse of his depression. He is able to describe how he would recognise signs of such a relapse. His Asperger Syndrome is a lifelong condition, and whilst he has demonstrated good understanding of this condition, and of his vulnerabilities, he requires restrictions at the present time to protect patients and himself, as he eases into working as a consultant again, and puts into practice some of the strategies he has learnt in CBT for managing stress. Such restrictions would help Dr Cook to seek access to support early, should his mental state deteriorate again due to work or other pressures. These would include continuing to remain in the care of his GP, continuing with any psychotropic or other medication as directed by his GP, and to a mechanism for identifying signs of early relapse in the workplace."

60. Viewed in this way, it is clear why the IOT was justified in relying upon Dr Reiss. Here was a clear positive recommendation for clinical supervision. There was nothing of substance to set against it. Dr Reiss's reasoning for the need for clinical supervision makes evident sense. It is carefully justified and rationally connected to the risk in the case. Dr Cook has suffered from and continues to suffer from mental health issues. As Dr Reiss puts it at §37 of the report:

> "Dr Cook has also provided a history of significant episode of depression and anxiety, dating back many years in his life. Although currently his depressive symptoms are in remission, with treatment, he continues to experience some symptoms of anxiety. He has had repeated episodes of depression, which have been at least of moderate severity and sometimes may well have been in the severe range, but without psychotic features. These episodes have lasted for some months, with recovery in between to a large degree. Individual episodes have been precipitated by stressful life events."

61. There are two significant features of the appellant's health problems. First, that they have been assessed as "recurrent" by both experts. There is therefore the risk of relapse. Second, that the risk of relapse is connected to stress in the workplace. This is the mechanism for Dr Cook's mental health deterioration in 2021 during the Covid

epidemic which resulted in his criminal conduct involving publication of obscene material about child sexual abuse. Given the outcome of his previous mental health relapse, the IOT was plainly correct to conclude that there is the risk of serious consequences with a further recurrence, which is not the same thing as a "real risk" to public safety.

62. The question then becomes how best to mitigate the risk and manage it in a way that reduces to the extent it is possible risk to the public interest and Dr Cook himself. Two further factors are pertinent. Dr Cook is returning to clinical practice after a break of 3 years. That is a substantial break in the continuity of practice for any professional, but the true significance is not around "deskilling" issues, which is what Dr Cook argues that the IOT improperly took into account (along with the failure to weigh Dr Deshpande's lack of clinical supervision recommendation (**Ground 2**)). In the appellant's skeleton (§52), it is submitted that, "It has never previously, during the course of these lengthy proceedings, been suggested that Dr Cook has become de-skilled and the only person who has raised it is Dr Reiss." Building upon this, it was further submitted that one should read into the Tribunal's decision that the imposition of the clinical supervision was about deskilling since the decision stated:

> "The Tribunal recognised, however, that Dr Cook had been away from clinical practice for some time."

63. While I accept the appellant's submission (ibid., §53) that Dr Reiss is "not a respiratory doctor" and that broadly the more senior the professional, the less likely she or he is to become deskilled over a short period of time, I do not regard the suggestion of deskilling to be a correct reading of the decision. The focus of the Tribunal was not on the deskilling of Dr Cook, but the risk of his mental health deterioration once reintroduced to the responsibilities of demanding clinical practice and its associated stressors. Dr Cook's absence from the day-to-day demands placed on a senior and highly specialised consultant is likely to render him not deskilled, but more sensitive to the stresses of the job in a way that once one is regularly immersed in the patterns and routine one is able to cope with and withstand more readily. This is the true and obvious significance of Dr Cook's hiatus, while his criminal case proceeded through the courts: there is likely to be a greater salience of and sensitivity to workplace stressors. This is especially so given the extreme challenges of the period that Dr Cook has gone through with very serious mental health problems and criminal proceedings resulting in conviction and sentence. This is the true reading of the Tribunal's decision, and is the conclusion this court reaches. In any event, the duty of the court is to assess what is the appropriate order.

64. The clinical supervision provides professional support for Dr Cook on his return to a strenuous professional environment and an early warning mechanism should any stress he experiences affect the quality of his patient-facing work, not due to deskilling but stress. As Dr Reiss puts it, and as noted by the Tribunal in its determination in September 2023, the package of conditions:

> "would be able to ensure that his duties are taking place to an appropriate standard, help reduce stress in the workplace, as well as provide an early warning of any difficulties, which could then be addressed promptly."

65. Indeed, at the September hearing, the Tribunal explicitly recognised that there was no evidence of clinical concerns (§14). Further, Dr Cook is on medication and the CBT therapeutic intervention that he has received remains untested in a clinical setting. As Dr Deshpande states (B538), Dr Cook:

> "requires restrictions at the present time to protect patients and himself, as he eases into working as a consultant again, and puts into practice some of the strategies he has learnt in CBT for managing stress."

66. Dr Reiss was clear about the concern, at §40 of the report:

> "Dr Cook's depressive and anxiety symptoms may deteriorate in the future, as they have a pattern of relapsing and remitting in the past, and the diagnosis of his depressive disorder is, by definition, recurrent. Relapse is particularly likely should Dr Cook suffer a significant psychological stressor in his life, such as loss of a loved one, or high levels of stress in the workplace."

67. It must be emphasised that a clinical supervisor would not be trained in identifying signs as an independent psychological or mental health expert, but the supervisor would offer Dr Cook a person to share any professional concerns or difficulties that he was experiencing during his return to work. While such a fellow professional is not a complete solution to providing an early relapse mechanism, this step could help mitigate risk by being a regular structured forum for the sharing of Dr Cook's concerns, which could then be passed on for further specialised assessment and support if the need appeared to arise. This is all about mitigating risk.

68. Given the nature and tenor of Dr Deshpande's report, I cannot conclude that she was hostile to clinical supervision or deemed it unnecessary. That is misinterpreting the thrust of her conclusions. At most, she is silent about such supervision. The Tribunal then had to consider whether to accept Dr Reiss's positive recommendation. It did. The court concludes that the Tribunal was evidently correct to do so. The supervision would be "light-touch", the least intrusive to Dr Cook. The expert supervisor would be perfectly placed to assess whether there was a deterioration in the quality of the clinical care provided by Dr Cook under stress. One has to consider the logic of the situation: if there has been no professional deskilling, should there be a deterioration in future performance, the obvious inference is that it is connected to workplace stress and its impact on Dr Cook's mental health. This was the previous mechanism that contributed to Dr Cook's criminality. Thus, performance deterioration may be a signal of or proxy for stress impacting mental health and would be just the kind of "early warning" alert that would justify further investigation.

69. It is clear that the Tribunal has a broad discretion in determining a package of measures best suited to address and reduce the risk presented by a practitioner. The breadth of this discretion is clear from s.41A(A1)(1)(b) of the Act, where the Tribunal can impose:

> "such requirements so specified as [the Tribunal] think fit to impose."

70. The imposition of clinical supervision and the locum-length condition would comfortably fit within that discretion. I cannot accept the further submission made by Dr Cook that the Tribunal misdirected itself and imposed a public safety condition

when it was not justified (**Ground 3)**: "The IOTs determination fails to explain why it concluded that there is a "real risk" to members of the public if Dr Cook practices without supervision" (Skeleton, §58). This argument fails to address the nature of the test. The short point is that this case is not about the first subclause of paragraph 27(a.), but the second. It is not a "real risk" case; it is about the imposition of conditions to protect the public interest and support the interests of Dr Cook on his return to the demands of clinical practice. The GMC did not seek the conditions on a "real risk" basis. The Tribunal did not impose the conditions on such basis. Ground 3 which advances this argument is misconceived. Rather, it is clear from the terms of the Tribunal's decision that the IOT imposed the condition based on the public interest and also the interests of the appellant. The Tribunal stated at §12:

> "The Tribunal has determined that, based on the information before it today, there are concerns regarding Dr Cook's fitness to practise which may adversely affect the public interest. After balancing Dr Cook's interests and the interests of the public, the Tribunal has decided that an interim order is necessary to guard against such a risk."

71. Nor is it a sound argument to submit that the Tribunal construed the expert reports as evaluating Dr Cook's clinical proficiency. Both Dr Reiss and Dr Deshpande were clearly focusing on Dr Cook's mental health, but in any event, the court must assess the appropriateness of the order as things stand.

72. A further point is taken by the appellant is that the decision does not identify which of Dr Cook's interests were taken into account and how they were outweighed by the public interest (**Ground 7**). The starting-point must be that the Fitness to Practise Rules place on the Tribunal a duty to give reasons for its decision (Rule 27(4)(g)). However, the obligation is to avoid being prolix, and to be "fairly concise" (Guidance §§69-70). This is particularly relevant as the IOT, by its function and the obviousness of its name, is making interim decisions, not making findings of fact. That is a vital context.

73. As to the appellant's "interests", it is obvious that Dr Cook ordinarily enjoys a right to earn a living by practising his chosen profession. It is a commonplace that such rights cannot be arbitrarily, unreasonably or disproportionately interfered with. The appellant places reliance on *Hussain v General Medical Council* [2012] EWHC 2991 (Admin), a first instance decision by HHJ Pelling QC, sitting as a Judge of this court. He held at [12]:

> "No attempt is made to explain why the panels concerned consider one piece of material more relevant than any others or whether particular arguments have been rejected, and if so why. Inevitably, therefore, the weight that can be given in particular to the decisions of those panels which were concerned with the question whether or not the conditions orders should be continued is limited."

74. However, as I have stated, what this court must consider is whether the decision of the Tribunal should stand or whether it is "wrong" in the way identified. This approach was also set out in *Hussain* itself (ibid.), where the court stated:

> "As I have explained, a case of this sort is not a review, and thus the adequacy of the reasoning of the Interim Orders Panel is not directly relevant to the issues I have to decide."

75. A reasons challenge is not usually a basis in itself, therefore, for this court to reach a different decision to the Tribunal. That is because when original powers are being exercised, there might be an insufficiency of reasons previously provided, but the substance of the decision may be correct (not "wrong"). Nevertheless, the level of reasoning provided may affect the weight that can be granted to the Tribunal's decision.

76. Should this have been a challenge by way of judicial review, the particularity of reasoning provided would have to be carefully examined in the decision's true context. There is no inflexible or prescribed level of elaboration required for adequate reasons. It is highly fact- and context-specific (*R (Lee-Hirons) v Secretary of State for Justice* [2017] AC 52, at [49], per Lord Reed). There needs to be sufficient detail for there to be no doubt about the decision and the reasons for it (*R (CPRE Kent) v Dover DC* [2018] 1 WLR 108, at [42], per Lord Carnwath).

77. It strikes me that the Tribunal's decision is manifestly "intelligible" and adequately reasoned in *South Bucks* terms (*South Bucks DC v Porter (No 2)* [2004] 1 WLR 1953, at [36], per Lord Brown), especially given that this is an interim order – the appropriate procedural context. It is correct, as the respondent submits, that extensive or exhaustive reasons are not required under the terms of the Tribunal's rules and guidance. In fact, the Tribunal is encouraged to be focused and succinct. Moreover, a transcript of the hearing can be prepared on request. The decision must not be viewed in isolation, but in context of the transcript, from which it is permissible for elements of the Tribunal's reasoning to be inferred. In this case, I have been provided with the transcripts of both the September 2023 and March 2024 hearings.

78. I cannot think what other interests Dr Cook would have had other than those stated above (and implicit in those is providing for his family). I do not regard the failure to spell out this obvious fact to materially reduce the weight the court can place on the Tribunal's decision. It is clear that in reaching its decision the Tribunal considered Dr Cook's interests in receiving support. In its September decision at §15, the Tribunal noted:

> "Whilst the Tribunal notes that the order continues to restrict Dr Cook's ability to practise medicine it is satisfied that the order imposed is the proportionate response."

79. In March, the question was whether the conditions should be maintained. Therefore, in its overall considerations, the Tribunal has unquestionably recognised the restrictions that conditions would impose on Dr Cook professional practice and weighed them against the public interest arising from the serious concerns arising from his mental health and connected misconduct.

80. That the interests of the appellant were considered by the Tribunal can be seen from §13 of its March 2024 decision, where the Tribunal considered "that an interim order is also in Dr Cook's own interests, given the concerns about his health" and the test

was met "on the grounds of public interest and the doctor's own interests." Thus, the Tribunal did consider the need for support for the appellant due to his mental health.

81. That said, and as I have emphasised, this court has stepped back and reviewed the totality of the evidence, including the new evidence that post-dates the Tribunal's decision, to determine whether the IOT's order should be varied or revoked. That course is authorised by Rule 8.6 which confers on the court a discretion to receive evidence that was not filed with the claim form (*Sandler* at [20]). Having considered everything, the court is satisfied that there is nothing in the reasons challenge.

82. Dr Cook alleges that he was not provided with the opportunity to address the IOT on relevant matters (**Grounds 5 and 6**). Whether that is correct or not, this court has offered Dr Cook the opportunity to develop his case fully through his counsel in written and oral submissions, and through the filing of evidence. The submission that no opportunity was provided to Dr Cook to address the question of the "real risk" requirement is misconceived. This was not the basis of the Tribunal's decision. I deal with the substance of the locum-length condition in the next section, but consider the procedural fairness aspect here in examining procedural challenges. It is submitted by the appellant that, "As to the introduction of a condition that any locum post must be for a minimum of 8 weeks, the Tribunal failed to indicate to the parties that this was being considered and therefore denied Dr Cook an opportunity to make submissions on it" (Skeleton, §60).

83. Once more, the critical point about this fairness challenge is that Dr Cook has had every opportunity to address this court on the substantive merits of the condition and there cannot be any plausible issue of procedural impropriety remaining. The court's focus must be on the appropriateness of the locum condition. While conceivably matters such as procedural fairness may affect the weight that can be placed on a tribunal's decision, these grounds are archetypal judicial review grounds and do not advance Dr Cook's case here about the substantive appropriateness of the order as it stands.

84. That said, I judge the challenge to the proportionality of the order to be of a different nature. Without question, the Tribunal's order must be proportionate. Several arguments were advanced by the appellant under this heading (**Grounds 4 and 8**). For example, the appellant submits (Skeleton §59) that the Tribunal's failure to identify any real risk or evidence of risk "renders the condition of supervision and the imposition of the 8-week minimum on locum posts, disproportionate as they significantly limit the scope of the work which could be available to Dr Cook."

85. It is axiomatic that the proportionality entails the imposition of no more interference with Dr Cook's practice than necessary to achieve the legitimate aim of effective protection of the public interest (see broadly the Supreme Court's four-stage test outlined by Lord Reed in *Bank Mellat v HM Treasury (No. 2)* [2013] UKSC 39 ("*Bank Mellat*")). As made plain by the Court of Appeal recently (February 2024), proportionality is a matter of substance and should not be reduced to mechanistic technicality or process (*Dalston Projects Ltd & Ors v Secretary of State for Transport*, co-joined with *Eugene Shvidler v Secretary of State for Foreign, Commonwealth and Development Affairs* [2024] EWCA Civ 172).

86. In the instant case, the Tribunal imposed "the lightest level of clinical supervision". The Tribunal correctly reached the conclusion that something needed to be done to erect a mechanism around Dr Cook to support him and to safeguard the public interest from the consequences of any future mental health deterioration. The Tribunal's assessment of risk indicated to it not "close or direct clinical supervision", but the lowest level of such intervention. This was undoubtedly "rationally connected" to the risk posed and in *Bank Mellat* terms, causally connected to and furthering the legitimate objective which is to guard against it. It was the minimum intervention. It struck the fair and appropriate balance between on the one hand, Dr Cook's rights to work and earn a living and (a) the public interest in mitigating the risk and consequences flowing from any future relapse in Dr Cook's mental health and (b) Dr Cook's interest in professional support on the other. The assessment of proportionality must additionally involve an evaluation of the totality of measures viewed in the round, and the court will also examine the second challenged condition in light of and in combination with this first one. It is the proportionality of the package of measures that is critical.

87. A further argument made on behalf of the appellant is that the imposition of clinical supervision is "tantamount to a suspension". This is because finding a suitably qualified consultant of sufficient expertise and seniority to supervise Dr Cook, it is submitted, creates such an obstacle to his reinstatement that for all practical purposes he will be indefinitely suspended, even though such a sanction was not mandated by the Tribunal and indeed the suspension was lifted as Lane J indicated it should be.

88. The appellant points to an email dated 18 March 2024 (B974) from Ms Finnigan, a recruitment consultant at Doctors Direct. It states:

> "Preliminary credentialling checks have shown that you have conditions on your GMC registration, including the requirement for your clinical work to be supervised by a clinical supervisor. Due to the nature of locum work, I'm afraid it would not be possible to provide this level of support within assignments at our Partner Trusts. On this basis we cannot progress with your application."

89. An email (possibly dated 4 April 2024) from Pertemps Medical states that Dr Cook ("this doctor") would have to be rejected as he "needs supervision". A further email dated 12 April 2024 was included in the hearing bundle before the court. It was from the Barnsley Hospital NHS Foundation Trust. Ms Barker on behalf of the Trust states (B976-77):

> "As I am sure you [are] aware Respiratory services are under immense pressure and have been since the pandemic and there is currently no capacity within the team for the support it is felt will be required for you to take up the role given your absence from practice for a number of years and the requirement for supervision."

90. While the comment about his absence "for a number of years" may possibly be a reference to a concern about deskilling, the earlier focus of the Tribunal, as explained, was on public interest and support. Despite these communications post-dating the 15 March 2024 Tribunal review, the court in its discretion and in fairness to Dr Cook has fully considered the evidence under the procedural rules. The emails document practical difficulties in his securing a post, and consequently it is necessary for there

to be clear and convincing justification for the clinical supervision condition. Dr Reiss provides this. He states at §43 of his report:

> "Dr Cook's health condition, in particular his depressive disorder, has only relatively recently remitted with treatment and, should he relapse, it may adversely affect his performance in the workplace." (B523)

91. Dr Cook has had other conditions imposed on his practice, conditions he does not oppose. He accepts that he must have a workplace reporter who provides "regular feedback" to the GMC including about how the doctor is "progressing" (Guidance, February 2019 "Imposing interim conditions on a doctor's regulation" (B273)). Under the guidance (February 2019), this reporter could be the same person as the clinical supervisor, which would reduce the number of members of staff needing to be involved.

92. On 8 December 2023 (B647), Dr Cook notified Ms Breeze at the GMC that he had been offered and had accepted a 12-week locum position, and both the "responsible officer and clinical supervisor are fully aware of and happy to comply with my GMC conditions". This was the Barking Havering and Redbridge Hospitals University Trust. Dr Cook's clinical supervisor was identified as Dr Johns, who would also act as his direct line manager. Therefore, it is clearly not the case that the imposition of the clinical supervision condition operates as a suspension. The Trust in question was able to provide the requisite supervision. The position fell through for a different reason (B648), as made clear by Dr Howard, the Trust's Clinical Group Director, in an email dated 15 December 2023:

> "Unfortunately, following a safeguarding conversation at BHRUT we have decided to withdraw the offer of work to Dr Cook."

93. Therefore, the impediment was not the availability of clinical supervision, but the safeguarding risk that Dr Cook presented in the eyes of the Trust, a judgement it was justified in making based on its assessment of Dr Cook's previous conduct.

94. By a letter dated 14 March 2024 (B959), Dr Cook's solicitors note that one agency has indicated that it will stop searching for locum posts for him due to the reluctance of "employers" (that is, healthcare trusts) to engage him. It cannot be doubted that the appellant has faced difficulties in securing locum posts. That difficulty can and should be distinguished from an impossibility, with Barking having offered him a post. Further, the solicitor's observation relates to "one locum agency". Overall, the picture remains incomplete.

95. It is further submitted on behalf of the appellant that the Tribunal in effect operated a "reverse burden of proof" (**Ground 9**), improperly relying on a lack of evidence about the reasons for the appellant's lack of successful locum appointment. This amounts to a species of judicial review challenge, arguing that the IOT applied the wrong test. The court must be careful not to be drawn into judicial review-type analysis. As Laing J stated in *Howells* at [42]:

> "the task of this court is not to review the order for legal error but to consider whether the order is wrong. In other words, my concern is with the underlying factual merits of the order, whether or not it is flawed by legal error."

96. I judge that it was legitimate for the Tribunal to note the lack of "information" before it. This is not the same as imposing a burden upon the appellant to prove anything. The Tribunal manifestly must make a determination on all the evidence and part of that includes cognisance of gaps in the evidential landscape. That is unremarkable.

97. This court has carefully considered all the evidence Dr Cook has wished to put before it. The respondent realistically accepts that the supervision condition presents "some potential hurdle" to successful placement in a locum role. There is no witness statement from the appellant, and it was open to him to fully present the court with his experiences of seeking appointment. Consequently, it remains unclear what posts he has in fact applied for and the reasoning behind the outcomes. The court simply cannot conclude that the condition operates in a way that is "tantamount" to a suspension.

98. The respondent presses on the court that the order, should it stand, will be reviewed again in August 2024. That may be the case, but this fact does not displace or diminish the court's duty to determine whether the order, as it stands, should be varied or revoked.

99. It must be added briefly that **Ground 8** amounts to no more than a catch-all and recapitulation of the previous grounds. It adds nothing.

Conclusion: Clinical supervision

100. For all the reasons provided, it is absolutely clear to this court that the appropriate order in this case was to impose a condition of clinical supervision. This had nothing to do with deskilling, and everything to do with a sensitivity to the stressors that are likely to accompany the appellant's reintroduction to clinical work, and the mechanism of his mental health deterioration previously. The clinical supervisor does not perform a psychological assessment function, but instead is available to assess whether there are any issues in clinical performance that may be an indicator of an adverse reaction to workplace stress. Thus, the condition does not fall into the "real risk" category, but instead is a Subclause 2 intervention, being imposed to safeguard the public interest and to support the appellant as he seeks to re-establish his clinical practice. It would function as part of a broader package of conditions and restrictions and operates as part of an early warning mechanism responsive to any stress-related mental health relapse that the appellant remains vulnerable to experience.

§VII. CHALLENGED CONDITION 2: LOCUM-LENGTH

101. The appellant submits that it is unfair to impose a condition that any locum placement must be for a minimum of 8 weeks, and its effect is reimposing a suspension of medical practice. The respondent counters that the prohibition on taking up locum posts of fewer than 8 weeks is necessary to ensure that there is proper supervision and is not a disproportionate restriction given the nature of the case.

Discussion: Locum-length

102. The "fairness" challenge in respect of the locum condition has been dealt with and dismissed as misplaced, being redolent of a public law challenge. It does not survive this court's invitation to Dr Cook to develop the challenge to the locum condition in any reasonable way he wished.

103. The task of this court remains to determine what the appropriate order is and whether any conditions that are constituent parts of that are necessary and proportionate. In *Howells*, Laing J considered a 4-week locum restriction. She held at [35] that:

> "in considering whether that order is wrong the court should give the opinion of the IOP significant weight."

104. While the court finds that decision in *Howells* helpful, it must consider the matter carefully in light of the instant facts. It is emphasised that affording "significant weight" is not synonymous with the Tribunal's decision being determinative. The court must step back and assess whether the condition makes sense and is appropriate and proportionate in all the circumstances of the case. There is little point in a tribunal imposing a condition that is ineffective. Here this court has concluded that it is appropriate for Dr Cook to be subject to a condition of clinical supervision. The question is how to make that condition operationally effective and provide the safeguarding and support it is designed to promote. In *Howells*, the judge concluded at [63]:

> "the effectiveness of that requirement for supervision would be significantly reduced if Dr Howells could move from one post to another after two weeks, as the current requirement for supervision includes feedback at least once a fortnight. The IOP need to be satisfied that supervision will be effective and will minimise risks to patients."

105. The need for a measure of continuity of supervision is clear and the effectiveness of clinical supervision would be significantly undermined if the appellant were to move from hospital posting to hospital posting, with his supervisor having little opportunity to assess the level of performance before the appellant moved on.

106. I cannot accept the submission made on behalf of the appellant that *Howells* is irrelevant as it is a "clinical failings" case. While factually accurate, the significance of *Howells* is the insight Laing J offers about how the effectiveness of clinical supervision condition can be undermined by repeated short-term placements. I find that similar considerations about the need for continuity to apply notwithstanding that this is not a public safety case, but one concerned with the public interest and practitioner support ("interest").

Conclusion: Locum-length

107. A minimum duration of 8 weeks for a locum post is plainly necessary and proportionate to promote the vital objective of effective clinical supervision.

§VIII. DISPOSAL

108. For the reasons given in this judgment, the court has no hesitation in concluding that the order of the Tribunal to impose and then maintain the two challenged conditions was not wrong. The court has considered the proportionality of the two conditions individually and in combination, and the second supports and enhances the effectiveness of the first. They are not disproportionate on either analysis and do not operate as a de facto suspension.

109. This is a case in which public confidence in the proper regulation of the medical profession is acutely at stake. Dr Cook engaged in detailed, extensive and disturbing conversations about sexually abusing children. That these "fantasies", if that is the correct term, about having what would inevitably be extremely damaging sexual intercourse with children under the age of 10 may be attributable to Dr Cook's mental health disorder plainly necessitates careful supervision of his return to treating members of the public, with early warning mechanisms built in. The clinical supervision must be effective.

110. The requirements of such supervision by a suitably qualified senior practitioner, in combination with a requirement of a minimum locum placement of 8 weeks to ensure continuity and effectiveness of supervision, are necessary and proportionate in all the circumstances of this case. They are entirely appropriate. They are not wrong.

111. Dr Cook's application is dismissed.