ROYAL COLLEGE OF GENERAL PRACTITIONERS

WESSEX FACULTY

37th GEORGE SWIFT LECTURE 2019

The Implications of Bawa-Garba and the Boundaries of Professional Conduct

By Kenneth Hamer,[1] Henderson Chambers

Madam chair,[2] ladies and gentlemen, it is a great honour as well as a personal pleasure for me to give the 37th George Swift Annual Lecture in memory of Dr George Swift who pioneered GP training in Wessex and was a founder member of the Royal College of General Practitioners. These lectures began in 1981 when George Swift, himself, gave the inaugural lecture on the subject "Recollections and reflections: general practice since 1946". How times have changed in medicine since then!

The title of my talk this evening is *The Implications of Bawa-Garba and the Boundaries of Professional Conduct.* I shall attempt to trace the criminal and professional conduct proceedings in the case of Dr Hadiza Bawa-Garba, that has attracted wide publicity, along with the case of Honey Rose, an optometrist, who like Dr Bawa-Garba faced criminal proceedings of gross negligence manslaughter resulting from treatment to a child who tragically died. These cases are stressful and worrying for all involved and their implications impact seriously on issues of professional conduct and pose the question where do the boundaries lie? In expressing my views in this talk, let me straightaway say that they are my personal views, and should not be taken as necessarily those of any regulator or other body.

I deal, first, with the facts of each case.[3] Dr Bawa-Garba was and is a junior doctor specialising in paediatrics. In February 2011, she had recently returned to practice as a Registrar at Leicester Royal Infirmary Hospital after 14 months of maternity leave. She was employed in the Children's

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[3] The facts are largely taken from the judgments in *Hadiza Bawa-Garba v. The Queen* [2016] EWCA Crim 1841; and *R v. Rose (Honey)* [2017] EWCA Crim 1168, [2018] QB 328.

Assessment Unit of the hospital which would receive patients from Accident and Emergency or direct referrals by a GP. Its purpose was to assess, diagnose and, if appropriate, then treat children, or to admit then onto a ward or to the Paediatric Intensive Care Unit as necessary.

Jack Adcock was a six year old boy, who was diagnosed from birth with Downs Syndrome. As a baby, he was treated for a bowel abnormality and a "hole in the heart". He required long-term medication and in the past had been admitted to hospital for pneumonia. On the morning of Friday, 18 February 2011, Jack's mother, Nicola Adcock, took Jack to see his GP. Jack had been very unwell throughout the night and had not been himself the day before at school. The GP was very concerned, and he decided that Jack should be admitted to hospital immediately. Jack presented with dehydration caused by vomiting and diarrhoea and his breathing was shallow, and his lips were slightly blue. When Jack arrived and was admitted to the assessment unit at the hospital at about 10.15 am, he was unresponsive and limp. Dr Bawa-Garba was the most senior junior doctor on duty. For the following 8 – 9 hours he was in the unit under the care of Dr Bawa-Garba and two other members of staff. At about 7 pm, he was transferred to a ward. During his time at the unit, he was initially treated for acute gastro-enteritis (a stomach bug) and dehydration. After an x-ray he was subsequently treated for a chest infection with antibiotics. In fact, when Jack was admitted to hospital, he was suffering from pneumonia which caused his body to go into septic shock. The sepsis resulted in organ failure and, at 7.45 pm, caused his heart to fail. Despite efforts to resuscitate him, at 9.20 pm, Jack died. The cause of death given after a post mortem was systemic sepsis complicating a streptococcal lower respiratory infection (pneumonia) combined with Down's Syndrome and the repaired hole in the heart.

Honey Rose is a registered optometrist. She was first registered with the College of Optometrists on 13 February 2008. In 2012, she worked part time at Boots Opticians in Upper Brook Street, Ipswich as a locum optometrist. On 15 February 2012, Joanne Barker took her two children, Vincent and Amber, to Boots Opticians in Ipswich for routine eye tests and examinations. Vincent was aged 7 years and 9 months and Amber was nearly 5. On that day, Ms Rose was on duty. Vincent was unco-operative when she tried to use an ophthalmoscope to examine the back of his eyes, although she carried out a sight test after retinal images were taken by an optical consultant/assistant. Following Vincent's examination, Ms Rose recorded no issues of concern and said that Vincent did not need glasses. The clinical record card which she filled out recorded the visit as a routine check and that Vincent had had a few headaches over Christmas 2011, but now all gone. Vincent's mother and Amber also had sight tests and eye examinations carried out by Ms Rose. The three appointments lasted 1 hour and 40 minutes.

Five months later, on 13 July 2012 whilst at school, Vincent was taken ill and vomited. The school rang his mother at about 2:50 pm and she collected him and took him home. His condition deteriorated during the afternoon. Around 8 pm he was discovered to be cold to the touch and plainly very ill indeed. The emergency services were called, and paramedics attended. Efforts were made to resuscitate Vincent and he was rushed to Ipswich Hospital. By the time he arrived at hospital, however, Vincent was unfortunately in cardiac arrest. Every effort was made by the ambulance staff, doctors and nurses to resuscitate him, but after 40 minutes there was still no cardiac output. Following consultation with his parents, it was decided that resuscitation would be stopped, and Vincent was formally pronounced dead at 9:27 pm by the on-call paediatrician. Vincent had previously been a healthy, thriving and active boy, who had never before attended hospital.

When a child dies suddenly and unexpectedly, the Sudden Unexpected Death in Infants and Children Protocol, called SUDIC, is implemented. A post-mortem examination of Vincent revealed the cause of death had been acute hydrocephalus (i.e. an acute build-up of cerebrospinal fluid within the normal ventricles of the brain because its normal outlet had been blocked). The condition would have been discovered had Ms Rose examined the back of Vincent's eyes through an ophthalmoscope or "slit" lamp, and would have been treatable by surgical intervention up until the point of his acute deterioration and demise on 13 July 2012.

Dr Bawa-Garba and Ms Rose were each charged with gross negligence manslaughter. In the case of Dr Bawa-Garba the Crown's case was that she, together with the nurse on duty and ward sister, contributed to, or caused Jack's death, by serious neglect which fell so far below the standard of care expected by competent professionals that it amounted to criminal conduct. Following trial at Nottingham Crown Court Dr Bawa-Garba and Nurse Amaro, the nurse on duty, were both convicted by a jury and each was sentenced to 2 years' imprisonment suspended for 2 years. The ward sister was acquitted. In December 2016, Dr Bawa-Garba's appeal was dismissed by the Court of Appeal, Criminal Division, but the Medical Practitioners Tribunal Service decided not to erase her name from the medical register and instead to suspend her registration for one year. Her registration is now subject to conditions although she has yet to resume clinical practice. Nurse Amaro was struck off by the Nursing and Midwifery Council.

Ms Rose too was convicted by a jury and sentenced to 2 years' imprisonment suspended for 2 years, but her appeal was allowed by the Court of Appeal, Criminal Division on the ground that the trial judge misdirected the jury on a point of law. The Court of Appeal held that to be guilty of gross negligence manslaughter Ms Rose would have had to have reasonably foreseen a serious and

obvious risk of death at the time of her examination of Vincent, which was not made out on the facts.[4] However, Ms Rose remains suspended from practising her profession.

These cases show us a number of things. First, that a healthcare professional may face both criminal and professional conduct proceedings arising from the same incident or set of facts. The modern era of regulation of the medical profession began with the Medical Act 1858. The 1858 Act brought together the disciplinary processes of the Royal College of Physicians that was first chartered in 1518, the College of Surgeons established in 1745, the Society of Apothecaries and other medical bodies. It provided for the establishment of the General Council of Medical Education and Registration of the United Kingdom, later to be called the General Medical Council. Section 29 stated that if any registered medical practitioner shall be convicted in England or Ireland of any felony or misdemeanour, or in Scotland of any crime or offence, or shall after due inquiry be judged by the General Council to have been guilty of infamous conduct in any professional respect, the General Council may, if they see fit, direct the Registrar to erase the name of such medical practitioner from the register. These provisions are reflected today in the fitness to practise processes in the Medical Act 1983 and the Opticians Act 1989, which govern the medical and optical professions.

Secondly, the regulator will usually allow the criminal proceedings to proceed first to a conclusion. However, an acquittal in the criminal proceedings is no bar to subsequent professional conduct proceedings. Double jeopardy plays no part in this area of the law.[5] The whole process may last some years before being completed. During this time the practitioner's career may be on hold, often subject to an interim suspension order or an interim conditions of practice order. Moreover, the practitioner may become de-skilled as a result of lengthy court and regulatory investigations and proceedings.

Thirdly, it is important to bear in mind that there is a fundamental difference between the task and necessary approach of a jury on the one hand and that of a tribunal in professional conduct proceedings on the other hand. The task of the jury is to decide the guilt or absence of guilt of the defendant having regard to his or her past conduct. The task of the tribunal, looking to the future, is to decide what sanction would be most appropriate to meet the objectives of the regulator.[6] Section

[4] The offence of gross negligence manslaughter requires breach of an existing duty of care which it is reasonably foreseeable gives rise to a serious and obvious risk of death and does, in fact, cause death in circumstances where, having regard to the risk of death, the conduct of the defendant was so bad in all the circumstances as to go beyond the requirement of compensation but to amount to a criminal act or omission; per Sir Brian Leveson P handing down the judgment of the court in *R v. Rose (Honey)* [2018] QB 328 at para 77; see further *R v. Rudling* [2016] EWCA Crim 741 at para 18, and *R v. Sellu* [2017] 4 WLR 64.
[5] *R (Redgrave) v. Commissioner of Police of the Metropolis* [2003] EWCA Civ 4, [2003] 1 WLR 1136 CA.
[6] *General Medical Council v. Bawa-Garba (British Medical Association and others intervening)* [2018] EWCA Civ 1879, [2019] 1 WLR 1929 CA at [76].

1 (1A) of the Medical Act 1983 provides that the over-arching objective of the General Medical Council in exercising their functions is the protection of the public. This involves the objectives to protect, promote and maintain the health, safety and well-being of the public; to promote and maintain public confidence in the medical profession; and to promote and maintain proper standards and conduct for members of the profession.[7] Similar provisions appear in the Opticians Act 1989, and in the legislation of all the healthcare professions.

On 11 June 2018 the Secretary of State for Health and Social Care announced that the Government would support the recommendations of the Williams Review into gross negligence manslaughter in healthcare. Professor Sir Norman Williams' report *Gross Negligence Manslaughter in Healthcare*[8] was set up to consider the wider patient safety impact resulting from concerns among healthcare professionals that simple errors could result in prosecution for gross negligence manslaughter, even if they occur in the context of broader organisation and system failings. Despite reports to the contrary, investigations of gross negligence manslaughter in healthcare are unusual, prosecutions are rare and findings of guilty are rarer still.[9] There is no doubt, however, that recent cases have led to an increased sense of fear and trepidation, creating great unease within healthcare professions. The Williams report was clear that healthcare professionals could not be, or seen to be, above the law and needed to be held to account where necessary. It was equally evident, however, that for the sake of fairness, the complexity of modern healthcare and stressful environments in which professionals work must be taken into consideration when deciding whether to pursue a gross negligence manslaughter investigation. The Williams report made a series of recommendations[10] designed to see that systemic issues and human factors will be considered alongside the individual actions of healthcare professionals where errors are made that lead to a death, ensuring that the context of an incident is explored, understood and taken into account. Additionally, bereaved families need support through being informed, in a timely manner, of events; being provided with the opportunity to be involved throughout investigative and regulatory processes; and at all times treated with respect and receive honest explanations when things have gone wrong.

[7] Section 1 (1B) of the Medical Act 1983

[8] https://www.gov.uk/government/publications/williams-review-into-gross-negligence-manslaughter-in-healthcare

[9] In the period January 2013 to March 2018, a total of 151 cases were investigated by the police and CPS resulting in no further action in 128 cases, 4 convictions and 3 acquittals and 16 ongoing cases.

[10] Recommendations include a clear explanatory statement of the law of gross negligence manslaughter and updated guidance and understanding of where the threshold for prosecution lies, improving assurance and consistency in the use of experts in gross negligence manslaughter cases, consolidating expertise in healthcare settings in support of investigations, and improving the quality of local investigations.

In addition to the Williams Review, the General Medical Council commissioned its own review of gross negligence manslaughter and culpable homicide, which reported in June 2019.[11] Its focus was on how the systems, procedures and processes surrounding the criminal law and medical regulation are applied in practice and how they can be improved to support a more just and fair culture. The review recognized that many doctors feel unfairly vulnerable to criminal and regulatory proceedings should they make a mistake which leads to a patient being harmed. The review made 29 recommendations. These included steps to rebuild the GMC's relationship with the profession; that the GMC should work with others across the healthcare systems to ensure that the importance of an inclusive culture is understood within the workplace; and that where a doctor is being investigated for gross negligence manslaughter or culpable homicide, the appropriate external authority should scrutinise the systems within the department where the doctor worked. Where the doctor is a trainee, this should include scrutiny of the education and training by bodies responsible for education and training. In short there needs to be better system scrutiny and assurance.

In the *Bawa-Garba* criminal proceedings, the trial judge in his sentencing remarks took into account the circumstances in which the offences took place, and that the children's unit at the hospital was a busy ward and could not limit its intake, but said there was a limit to how far these issues could be explored in a criminal trial, although there may be force in the argument that the defendants' responsibility was shared with others. This aspect was explored further in the subsequent fitness to practise proceedings against Dr Bawa-Garba and figured extensively in the determinations on impairment and sanction of the Medical Practitioners Tribunal. The tribunal found that Dr Bawa-Garba's actions marked a serious departure from *Good Medical Practice and* contributed to Jack's early death which continued to cause great distress to his family. Multiple systemic failures were identified by the Trust in its investigation following the incident. The Trust investigation included failings on the part of the nurses and consultants, medical and nursing staff shortages, IT system failings which led to abnormal laboratory test results not being highlighted, deficiencies in handover and accessibility of the data at the bedside, and the absence of a mechanism for an automatic consultant review. The tribunal found that Dr Bawa-Garba's fitness to practise was and remains impaired by reason of her conviction, but it was satisfied that the risk of her putting a patient at unwarranted risk of harm in the future was low. There was no evidence of any concerns being raised regarding Dr Bawa-Garba's clinical competency before or after the offence and there was no evidence to suggest that her actions on 18 February 2011 were deliberate or reckless. She was described by colleagues as an excellent doctor who had also reflected deeply on the events and

[11] *Independent review of gross negligence manslaughter and culpable homicide,* June 2019, published by GMC.

demonstrated significant and substantial insight. The tribunal concluded that the goal of maintaining public confidence in the profession would be satisfied by suspension of Dr Bawa- Garba's registration.

As is well known, and was widely reported in the press, the General Medical Council appealed the sanction decision and the Divisional Court quashed the tribunal's direction of 12 months' suspension and substituted a direction of erasure from the medical register.[12] Dr Bawa-Garba was granted permission to appeal and her appeal was eventually successful in the Court of Appeal.[13] In giving the judgment of the appeal court Lord Burnett of Maldon CJ, Sir Terence Etherton MR and Rafferty LJ said that the tribunal had been entitled to take into account that an important factor weighing in the doctor's favour was that she was a competent and useful doctor who presented no material danger to the public, and can provide considerable useful future service to society; and that the tribunal in carrying out an evaluative judgment was best qualified to judge what measures were required to maintain the standards and reputation of the profession.[14] Consequently, the suspension imposed by the tribunal was restored and the matter remitted to the MPTS for review.

On 9 April 2019 a tribunal determined that Dr Bawa-Garba's fitness to practise remained impaired by reason of her conviction but that her suspension from the register should be replaced by a conditions of practice order for 24 months. In the case of Honey Rose, she remains suspended under an interim order pending determination of her case before the Fitness to Practice Committee of the General Optical Council.[15]

What then are the implications of these and similar cases and where are the boundaries of professional conduct in cases involving gross negligence manslaughter? In considering the effect or consequences of the Bawa-Garba and Honey Rose cases, it seems to me that the striking feature is how society can fairly and justly balance the disparate interests of the patient and the doctor and the state and the regulator. I have already referred to the interests of and the support required to the bereaved families. These must be balanced against the rights of the doctor whose interests require to be protected by a fair investigation and trial process. Anonymity of the practitioner in any criminal or regulatory proceedings is unlikely save where the health or the need to protect the privacy or confidentiality of the practitioner outweighs the public interest. We live in a society of open justice and the press plays an important role and, subject to well established exceptions,

[12] [2018] EWHC 76 (Admin); [2018] 4 WLR 44, DC
[13] [2018] EWCA Civ 1879; [2019] 1 WLR 1929, CA
[14] See paras 93-97 applying *Bijl v. General Medical Council* [2002] Lloyd's Rep Med 60 at [13]; *Marinovich v. General Medical Council* [2002] UKSC 36 at [28]; and *Khan v. General Pharmaceutical Council* [2017] 1 WLR 169, SC at [36].
[15] Review of Interim Order dated 16 August 2019.

hearings are conducted in public. This may be hard on the individual healthcare worker, who may have an otherwise unblemished career and the incident may be an isolated act or series of events in the course of treatment or care to a single patient, but this must be balanced against the overarching objectives to promote and maintain public confidence in the profession concerned and maintain proper standards of conduct for members to abide by.

It remains to be seen how the recommendations of the Williams Review and the GMC's own review will change the cultural environment and provide better reassurance to healthcare professionals, patients and families in cases of gross negligence manslaughter. Both reviews recognized the concerns expressed by many healthcare professionals about the possible use of reflective records and other reflective material, such as e-portfolio reflective statements, in prosecuting a healthcare professional for gross negligence manslaughter. The GMC has stated that reflection is central to learning and to safe practice and fundamental to medical professionalism. Reflection supports doctors' learning and may lead to better personal insight and improved practice and better patient safety. At no point during the criminal trial was Dr Bawa-Garba's e-portfolio reflective statement presented to the court or jury as evidence. The doctor shared some personal reflection with the tribunal in the fitness to practise proceedings to demonstrate the steps she had taken to remediate her practice.

The Human Rights Act 1998 plays an important part in criminal and regulatory proceedings. The Act incorporates into English law the European Convention on Human Rights. Article 6 of the Convention provides for a right to a fair trial in criminal and civil proceedings and confirms the common law rule that everyone charged with a criminal offence shall be presumed innocent until proved guilty according to law. In criminal and civil proceedings the burden of proof remains throughout on the prosecution or the regulator whatever the nature of the proceedings. Article 2 of the Convention provides that everyone's right to life shall be protected by law. Following a sudden and unexpected death there may be an inquest,[16] and a police investigation which may lead to a decision by an independent prosecuting authority whether to bring criminal proceedings against the practitioner. It has been held that there is nothing in the Strasbourg or domestic jurisprudence that requires disciplinary proceedings to be taken in order to meet the requirements of article 2,[17] although it

[16] See *R (Middleton) v. West Somerset Coroner and another* [2004] UKHL 10, [2004] 2 AC 182 where at [20] Lord Bingham of Cornhill said that in England and Wales an inquest is the means by which the state ordinarily discharges its obligation under article 2.

[17] *R (Birks) v. (1) Commissioner of Police of the Metropolis and (2) Independent Complaints Commission and Rigg-Samuel (Interested Party)* [2018] EWHC 807 (Admin) at [46] *et seq*

would be for the court, if necessary, to determine whether there has been sufficient scrutiny such that it is not necessary to pursue disciplinary proceedings.

In Bawa-Garba and Honey Rose there was plainly serious negligence in each case. In allowing the appeal in the criminal proceedings in the *Honey Rose* case, the Court of Appeal said it did not, in any sense, condone the negligence that the jury must have found to have been established at a high level in relation to the way Ms Rose examined Vincent and failed to identify the defect which ultimately led to his death. That serious breach of duty, the court said, was a matter for her regulator, the General Optical Council.[18] Similarly, in the *Bawa-Garba* case, the jury found that the conduct was truly exceptionally bad and the tribunal found that Dr Bawa-Garba fell far below the standards expected of a competent doctor at her level. Her failings in relation to Jack were numerous, continued over a period of hours and included a failure to reassess Jack following her initial diagnosis or seek assistance from senior consultants. The real argument was over sanction and whether, as contended by the GMC, Dr Bawa-Garba's name should be erased from the register.

Any sanction imposed by a fitness to practise tribunal is not intended to be punitive but to protect patients and the public. Most tribunals will wish to explore the extent to which the practitioner has practised safely since the incident, has fully remediated any concerns about their clinical practice and has demonstrated real insight into the failings that brought the practitioner before the tribunal. A matter of importance is whether the conduct of the practitioner or deficiencies in professional performance are so egregious that nothing short of erasure or removal from the register is required. Undoubtedly, there are some cases where the facts are such that the most severe sanction, erasure, is the only proper and reasonable sanction.[19] The assessment of the seriousness of the misconduct, particularly when it relates to professional performance, is essentially a matter for the tribunal in the light of their experience. Much will depend on the evidence placed before the tribunal, the personal circumstances of the practitioner, what support the practitioner may have, and how great is the risk of putting a patient at unwarranted harm in the future.

At the MPTS most hearings are now chaired by a legally qualified lawyer and the tribunal will include at least one medical practitioner on it. The tribunal will be guided by any published sanctions guidance or policy issued by the regulator, but any sanctions guidance, which is said to be "indicative", is a starting point and the sanction imposed in each case must be fact sensitive and, crucially important, be judged as being fair and proportionate to the interests of the registrant when weighed against the backdrop of the public interest and the maintenance of public confidence in the

[18] *R v. Rose (Honey)* [2018] QB 328 at para 95
[19] *GMC v. Bawa-Garba* [2018] EWCA Civ 1879, per Lord Burnett of Maldon CJ at [87]

profession. Any sanction or penalty, like any sentence, is ultimately a matter of judgment for the tribunal or sentencer, rather than proof and in deciding what sanction, if any, to impose the tribunal will consider each of the options available under the legislation, starting with the least restrictive.

Bringing these strands together, the cases of Dr Bawa-Garba and Honey Rose each show that the process whilst lengthy is thorough and considerable care is taken in the interests of justice at each of the various stages of the process. The purpose of this lecture, however, is not to discuss case management but the implications of these and similar cases for the parties involved and the wider public. In her Fifth Shipman Report, Dame Janet Smith reminded us of the notorious case of Alfie Winn.[20] In 1982, Alfie Winn, a child aged eight years, became ill with vomiting and a high temperature. His general practitioner was called and attended upon Alfie, who was asked to open his mouth. The boy seemed comatose and the doctor said that if Alfie could not be bothered to open his mouth, he would not examine him. He prescribed an antibiotic. Two hours later, the family called an ambulance and Alfie was taken to hospital. He died four days later of meningitis. The professional conduct committee of the GMC found the facts proved and held that the doctor's behaviour did fall below acceptable standards. Nonetheless, it considered it did not cross the threshold for a finding of serious professional misconduct. The case attracted wide publicity with questions in Parliament and the GMC's then guidance *Professional Conduct and Discipline: Fitness to Practise,* known as the Blue Book, was amended to emphasise that the public are entitled to expect that a registered medical practitioner will afford and maintain a good standard of medical care.

The need to promote and maintain a good standard of medical care is reflected today in the words of section 1 (1A) of the Medical Act which, as I have mentioned, provides that the over-arching objective of the GMC in exercising their functions is the protection of the public, along with the objectives in section 1 (1B) of the Act which include to protect, promote and maintain the health, safety and well-being of the public.

Madam chair, the protection of the public and the health, safety and well-being of the public must surely be the aims of all concerned who are engaged in these distressing and often difficult cases, whether as doctor or other healthcare professional, regulator, employer, lawyer or associate. In discharging our respective functions, I am confident we will all keep well in mind the motto that the founders of this Royal College decreed, which is *Cum Scientia Caritas* – "Compassion [empowered] with Knowledge". Thank you.

[20] Fifth report of the Shipman Inquiry, 9 December 2004 (Cm 6394), paras 17.11 – 17.12

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10 October 2019