The Bar Tribunals & Adjudication Service

The Council of the Inns of Court

# Report of Finding and Sanction

**Case Reference:**

Ms Ramya Nagesh

The Director-General of the Bar Standards Board

The Chair of the Bar Standards Board

The Treasurer of the Honourable Society of: Lincoln's Inn, 2008.

## Disciplinary Tribunal

### Ms Ramya Nagesh

1. In accordance with an appointment made by the President of the Council of the Inns of Court contained in a Convening Order dated 17 April 2024, I sat as Chair of a Disciplinary Tribunal on 13-14 May 2024 to hear and determine 6 charges of professional misconduct contrary to the Code of Conduct of the Bar of England and Wales against Ms Ramya Nagesh, barrister of the Honourable Society of Lincoln's Inn, 2008.

### Panel Members

2. The other members of the Tribunal were:

   Stephanie McIntosh (Lay Member)

   Helen Norris (Lay Member)

   Aaminah Khan (Barrister Member)

   Scott McDonnell (Barrister Member)

## Charges

3. Save where expressly stated otherwise, Ms Nagesh admitted the factual basis of each of the charges, but denied all the alleged breaches of Core Duties and/or Rules of the Bar Standards Board Handbook version 4.6.

**Charge 1**

**Statement of Offence**

Professional misconduct, contrary to Core Duty 5 of the Bar Standards Board Handbook version 4.6.

**Particulars of Offence**

On 6th of December 2022, Ms Ramya Nagesh, a barrister, conducted herself in a way which was likely to diminish the trust and confidence which the public places in her or in the profession, in that she attended inquest proceedings at Pontypridd Coroner's Court to represent her lay client, a nurse witness, and was around 15 minutes late back from the luncheon adjournment without offering a credible explanation or apology for re- joining the hearing late.

**Charge 2**

**Statement of Offence**

Professional misconduct, contrary to Core Duty 5 of the Bar Standards Board Handbook version 4.6.

**Particulars of Offence**

On 6th December 2022, Ms Ramya Nagesh, a barrister, behaved in a way which is likely to diminish the trust and confidence which the public places in her (or in the profession), in that she attended inquest proceedings at Pontypridd Coroner's Court to represent her lay client, a nurse witness, and did not actively participate in the inquest without good reason, permission, or authority. In particular,

(a) Ms Nagesh, after her client gave evidence for over an hour, did not respond to the coroner who tried to repeatedly get her attention and ask if she had any questions, while

her camera was turned off and her initials were still on screen.

(b) Ms Nagesh, having been not actively participating in the proceedings, was not present to ask questions of her client when prompted by the coroner. This prevented any legal submissions on behalf of her client being made.

(c) Ms Nagesh's failure to actively participate in the proceedings caused significant additional work for the coroner's office, her instructing solicitor and her clerks, who all tried and failed to make contact during the proceedings.

(d) Ms Nagesh's failure to actively participate in the proceedings brought the inquest to a premature halt.

(e) Ms Nagesh's failure to actively participate in the proceedings meant that her instructing solicitor agreed to attend the remainder of the inquest.

(f) Ms Nagesh, when she reappeared on the inquest proceedings, had to be "reminded" on Regulation 28 evidence concerning her own client.

**Charge 3**

**Statement of Offence**

Professional misconduct, contrary to Core Duty 3, rC8 and rC9.1 of the Bar Standards Board Handbook version 4.6.

**Particulars of Offence**

Ms Ramya Nagesh, a barrister, failed to act with honesty and integrity and/or acted in a way which could be reasonably seen by the public to undermine her honesty and integrity, in that on 6th December 2022, she attended inquest proceedings at Pontypridd Coroner's Court to represent her lay client, a nurse witness, and knowingly and/or recklessly attempted to mislead the coroner, by providing the following explanations to explain her failure to actively participate in the inquest proceedings, which were not credible:

(a) Stating that "I am here, sorry, I've been here for a good number of, for about an hour and a half, so I..(inaudible words)";

(b) Falsely stating that she had heard her client give evidence during the afternoon session; and

(c) Claiming that there must have been an internet glitch which impacted on her virtual presence.

**Charge 4**

**Statement of Offence**

Professional misconduct, contrary to rC3.1 of the Bar Standards Board Handbook version 4.6.

Particulars of Offence

Ms Ramya Nagesh, a barrister, knowingly and/or recklessly attempted to mislead the coroner, in that on 6th December 2022, she attended inquest proceedings at Pontypridd Coroner's Court to represent her lay client, a nurse witness, and provided the following explanations to explain her failure to actively participate during the inquest proceedings, which were not credible:

(a) Stating that "I am here, sorry, I've been here for a good number of, for about an hour and a half, so I..(inaudible words)";

(b) Falsely stating that she had heard her client give evidence during the afternoon session; and

(c) Claiming that there must have been an internet glitch which impacted on her virtual presence.

**Charge 5**

**Statement of Offence**

Professional misconduct, contrary to Core Duty 1 of the Bar Standards Board Handbook version 4.6.

**Particulars of Offence**

Ms Ramya Nagesh, a barrister, failed to observe her duty to the court in the administration of justice by not actively participating in the inquest proceedings which took place on 6 December 2022 at Pontypridd Coroner's Court, from approximately

13:45pm to around 16:00pm, in which during this period she failed to make effective contributions to the proceedings.

**Charge 6**

**Statement of Offence**

Professional misconduct, contrary to Core Duty 2 and Core Duty 7 of the Bar Standards Board Handbook version 4.6.

**Particulars of Offence**

Ms Ramya Nagesh, a barrister, failed to act in the best interests of her client and/or failed to provide a competent standard of work and service to her client, in that, on 6 December 2022, she attended inquest proceedings at Pontypridd Coroner's Court to represent her lay client, a nurse witness, and failed to represent her client properly which had the impact as set out at a) to f) in charge 2 above.

## Parties Present and Representation

4. The Bar Standards Board ("BSB") was represented by Mr David Welch. The Respondent was present and was represented by Neil Sheldon KC.

## Preliminary Matters

5. As per the agreed Standard Directions, the live medical evidence given by Dr Munro was heard in private.

## Findings and Reasons:

6. On 14 May 2024 the Tribunal made the following statement on their findings.

7. This is the unanimous decision of the Tribunal

8. Ms Ramya Nagesh, a registered barrister who was called to the Bar in November 2008, appears before this Tribunal on 6 charges of professional misconduct, all of which charges she denies. All of the charges arise out of the Respondent's conduct at an inquest before an assistant coroner in Pontypridd on 6 December 2022**.** The Respondent was representing HC, a nurse.

9. The Tribunal had the benefit of skeleton arguments and oral submissions by both counsel. This judgment is delivered at the conclusion of evidence and submissions on the second day of the hearing.

10. The BSB did not call any live evidence. It relied on correspondence from the assistant coroner and the transcript of the hearing of the day in question, together with an audio recording of relevant part of the inquest.

11. The following witnesses gave oral evidence: the Respondent, Dr Neil Munro, a consultant neurologist with a particular expertise in the neurophysiology and clinical features of sleep disorder; and Mr David Perry KC and Mr Phillip Rule KC who gave character evidence. Although the BSB had informed the Respondent that the evidence of Mr Perry and Mr Rule was not challenged, they nevertheless they came to give evidence because they held the Respondent in particularly high regard and wished to impress that upon the Tribunal.

12. The following people, who had provided witness statements which were not challenged by the BSB, were not required to attend for cross-examination: [redacted], who is now the husband of the Respondent, [redacted], the Respondent's mother, and from [redacted] the Respondent's sister.

13. The background to the charges is as follows. The Respondent was briefed to attend an inquest on 6 December 2022 in Pontypridd to represent HC. In advance of the inquest, she had been permitted to attend by video link. On the nights of 4 and 5 December 2022,

she stayed in an hotel in Stockport where she had stayed previously. At the time of the Pontypridd inquest, the Respondent was also briefed in a long running inquest in Stockport, but she had been released from that inquest for the day of 6 December to enable her to appear at the Pontypridd inquest.

14. The morning of 6 December appears to have been uneventful, save for some difficulty of some audio equipment which did not concern this Tribunal. However,, in the afternoon, problems began, which gave rise to complaints by the assistant coroner about the behaviour of the Respondent, followed by a report to the Bar Council, and ultimately to the six charges.

15. At the end of the morning session at 12.40, the inquest was adjourned until 1:30pm, a time which the assistant coroner mentioned three times in order to check that all the participants had understood and would be able to resume at that time. The Respondent did not indicate that it would be inconvenient for her. Nevertheless, the Respondent did not re-attend at 1.30pm; she was 11 minutes late. During the luncheon adjournment, she had emailed the clerk to the assistant coroner to check the start time, but it seems that she did not check the reply. When the Respondent returned, she said 'sorry' and the assistant coroner said no more about it and pressed on. The Respondent's evidence was that during the luncheon adjournment she had bought lunch, eaten part of it, and had fallen asleep on the bed.

16. **Charge 1** alleges professional misconduct contrary to Core Duty 5. The alleged factual basis of the charge is that the Respondent was around fifteen minutes late and did not offer a credible explanation or apology for rejoining the hearing late. The charge appears to allege that the Respondent offered no apology. If so, that is wrong. It is clear from the transcript that the Respondent did apologise.

17. The Respondent's explanation on 6 December for her lateness was "I missed the timings". In her statement, dated 26 January 2024, and with the benefit of the transcript and audio recording, the Respondent said that she did not remember hearing the resumption time

mentioned and that she had the impression that the inquest would resume at 1.45 and that she must have misheard or misremembered what the assistant coroner said. She went on to say that she was not sure what time the hearing would resume so she emailed the assistant coroner's clerk at 13.22 to ask what time the hearing was going to resume, but that she did not see the reply at the time. She had nodded off during the adjournment and when she rejoined the hearing and saw that the assistant coroner was already seated, she thought she was perhaps a couple of minutes late. She did not realise at the time that she was 11 minutes late and that efforts had been made to contact her. In cross examination Mr Welch pointed to the fact that the 1:30pm resumption time was mentioned three times, and that there was an e-mail with a reminder about the 1:30pm time. The Tribunal took the view that it is not unusual in court proceedings for the advocates involved to miss timings perfectly innocently; they often have a lot to consider over luncheon adjournments, and in this case, the Respondent had said to the assistant coroner that she was going to look up a couple of points during the luncheon adjournment. For those reasons, The Tribunal did not find the explanation to be incredible. The Tribunal came to that view even without taking into account the medical evidence. Moreover, the unanimous conclusion is that being eleven minutes late to a hearing, possibly particularly a hearing conducted remotely, offering an immediate apology, and the hearing then proceeding, would not lead a member of the public to lose trust or confidence in the profession. Charge 1 was not made out and was dismissed.

18. It is notable that by the time the charges were drafted (August 2023) and served (September 2023) the BSB had received the transcript of the hearing on 6 December and had also received the first report of Dr Munro (May 2023). It is regrettable that, notwithstanding the receipt of the transcript in June 2023, the charge was *offering no credible explanation or apology,* the wording of which mirrors what the assistant coroner had said in her letter of the 13 December 2022 to the Respondent.

19. All of the other charges required careful consideration of the medical evidence.

20. **Charge 2**, which alleges breach of Core Duty 5, relies on a number of particulars set out at a) to f). In all but two of the particulars, the charge as originally drafted alleges that the Respondent was *absent* and *not present* at the hearing. These words appear to have been adopted because the assistant coroner, having learned in the course of the inquest that the Respondent was briefed simultaneously in an inquest in Stockport, was suspicious that the Respondent was not really attending the Pontypridd inquest, but was devoting her time to an inquest elsewhere. The Tribunal concluded that any member of the public reading the charges, would assume it meant that the Respondent was not physically present on the video link. When the Tribunal invited Mr Welch to help on this matter, he suggested that the word *absent* was not limited to physical absence, but it was a broad term, wide enough to include *failure to participate fully, failure to take notes, failure to ask questions*. the Tribunal had no hesitation in in rejecting that submission. Mr Welch eventually applied to amend the charges so that wherever the words *absence* or *absent* or *not present* appeared, it was substituted by *failure to participate actively*. The application to amend was not opposed. It is noteworthy that at no stage had the Respondent or Mr Sheldon on her behalf sought to take technical points.

21. The factual bases of the particulars under Charge 2 are admitted save that, at Charge 2 b) it is denied that the Respondent's failure to participate fully prevented her from making legal submissions. The Respondent's unchallenged evidence was that she sent written submissions to the court in advance of the hearing. In her written response to Charge 2d) the Respondent admits that her conduct brought the Inquest to a *premature halt* in the sense that there was an adjournment so that steps to contact her could be taken. The words *premature halt* are again words used by the assistant coroner in her letter to the Respondent. The Tribunal noted that the inquest did not come to a complete halt but rather it resumed after a pause, and the assistant coroner delivered her judgment that day. All of the other particulars under Charge 2 were admitted.

22. The question which remained is whether the admitted facts underlying Charge 2 amount to professional misconduct. Here, the medical evidence is critical. Dr Munro provided two reports, the first in May 2023 and the second in January 2024. In essence, his evidence

was that at as of 6 December 2022, the Respondent had an undiagnosed medical condition, namely fatigue and excessive sleepiness (as medically defined), which caused her to be in a state of partial sleep resulting in confusion, impaired cognition, and impaired memory and insight. In Dr Munro's opinion there were a number of factors which had brought about the Respondent's medical condition. Those factors included an episode of COVID in February and March 2022. The Respondent, in common with many people of Asian heritage, was particularly badly affected by COVID. Other factors included parasomnia and acute sleep deprivation in the days before 6 December and Vitamin D deficiency. In his first report, Dr Munro spoke of the Respondent's vitamin D *inefficiency,* but in his second report, he spoke of vitamin D *deficiency,* explaining that the latter was based on American standards. In cross examination, in a tone that occasionally became mocking in the Tribunals view, Mr Welch sought to undermine Dr Munro's evidence. Mr Welch sought to persuade the Tribunal to disregard American standards for the simple reason that they were American. He contended that American experts were notoriously partisan and tended to write reports to shore up their clients' cases. As the Tribunal understood Dr Munro's evidence, the American standards are based on scientific evidence, not on the opinion evidence of experts instructed in any particular case. Mr Welch's opening and closing submissions were that Dr Munro's evidence was vague and inconclusive. He submitted that Dr Munro had a hypothesis and that there was no evidential basis to justify applying that hypothesis to the circumstances of this case.

23. The Tribunal considered all of Dr Munro's evidence with care. The Tribunal found him to be an impressive witness. His evidence accorded with the history given by the Respondent herself of her sleep difficulties, her concern about feeling fatigued and confused which had led her to seek medical attention in October 2022, her habitual long working hours, and of the stress she was experiencing at the time as a result of circumstances that need not be set out here. His opinion also accorded with the unchallenged evidence of the Respondent's sister and husband of the Respondent's parasomnia. Mr Sheldon highlighted the evidence of the Respondent's mother which he suggested illustrated the Respondent's impaired memory at the time. Having been alerted on 6 December by the Respondent's husband (then fiancé) that attempts to

contact the Respondent had failed, she too had tried to call the Respondent and had managed to speak to her that day. She said the Respondent had sounded upset, but did not seem to know exactly what had happened. The Respondent had told her mother that she had been a bit late back to a hearing and that the coroner had been *barking at her* and *seemed annoyed*, but that she did not understand what had happened. She had been very upset, clearly not able to give any of the details, and had been keen to get back to work and needed to speak to her client. A few months later when the Respondent and her mother had been discussing the complaint, the Respondent had had no recollection of having spoken to her mother that day. The Tribunal judged that this evidence supports Dr Munro's opinion. HC commented that when the Respondent rejoined the video link in the afternoon, her speech was slurred, and she looked drowsy as if she had fallen asleep or was possibly under the influence of substances. In the audio recording, which the Tribunal listened to with care, the Respondent's speech was indeed slurred, and she appeared confused when she tried to insert the key card switch on the lights. Mr Sheldon properly cross-examined the Respondent on why she should struggle to switch on the lights given that she was familiar with how the lights worked having stayed in the same room before and must have known how the lights worked. Dr Munro's evidence, which the Tribunal accepted, was that the Respondent was unlikely to have been fully asleep during the afternoon but that it was likely that she had been in a fluctuating state of partial sleep with differing levels of consciousness and functioning.

24. Turning to the Respondent's evidence, the Tribunal found the Respondent to be a completely reliable, honest and credible witness. Given that two months prior to the inquest the Respondent had sought medical advice for excessive sleepiness and confusion and that tests were being undertaken to ascertain the cause, it cannot be said that she was latching on to a convenient hypothesis to explain her conduct in December 2022. In fairness to the BSB and to Mr Welch, no such suggestion was ever advanced. However, there was implied criticism of the Respondent in cross-examination when she was asked why she had not said at the time to the assistant coroner *look, I may have some medical problem and it's being investigated.* The Respondent's evidence, which the Tribunal accepts, was that on that day she was very confused, she did not know what was

happening and that she would not have considered it appropriate, in a public hearing, to start talking about her medical condition. At no stage did the Respondent embellish her evidence. The fact that she could remember things at certain times and not at others or vice versa, did not undermine her evidence. She told the Tribunal candidly that it was difficult to know the extent to which her recollection had been influenced by what other people had told her about that day.

25. The Tribunal accepted the point made by Mr Sheldon in closing submissions, to the effect that had the Respondent been in the room where the inquest was being held it is likely that someone would have noticed that she was struggling, and that steps would have been taken to check that she was all right, and perhaps to suggest a break. The Tribunal rejected, without hesitation, the suggestion that during the afternoon session she was asleep on the bed. There was simply no evidential basis for such a suggestion. The Tribunal accepted the Respondent's evidence that throughout the hearing she was sitting at her chair in front of the computer. The Tribunal noted that there is no evidence that she logged out at any time during the afternoon session. In her response to the assistant coroner's letter, the Respondent suggested that she had logged out, but when she checked the transcript, she found out that that was not the case. She was logged in at 13:41pm and she was still logged in at around 16:00 hours and at 16:45.

26. The Respondent argued that admitted facts underlying Charge 2 do not amount to professional misconduct because her conduct on the day in question was attributable to the medical condition from which, unbeknownst to her, she was suffering at that time. On the basis of all the evidence The Tribunal read and heard, the Tribunal agreed. Charge 2 was dismissed.

27. **Charge 3 and Charge 4** may be taken together. **Charge 3** alleges *a failure to act with honesty and integrity*, in that the Respondent *knowingly or recklessly attempted to mislead the coroner.* **Charge 4** alleges professional misconduct in that the Respondent *knowingly or recklessly attempted to mislead the coroner.* Both charges rely on the same

three particulars. Both are very serious. (The particulars are listed a)-c) under Charge 3 but as d) -f) under Charge 4. Since there is no a) -c) under Charge 4, it is assumed that this is typing mistake and that they should appear as Charge 4 a)-c) which is how they are dealt with below.)

28. As to the wording of Charges 3 and 4, the Tribunal noted that initially the particulars under point a) alleged that the Respondent had said "I have been here all along". In fact, she never said "I have been here all along", that was the phrase used by the assistant coroner in her letter of December 2022 "your claim that you had been here all along I find very difficult to believe." The BSB simply repeated those words in the charge instead of cross-checking with the transcript. It was not until the day of the hearing that the BSB quoted correctly from the transcript. What the Respondent said was "I am sorry, I've been here for a good number of, for about an hour and a half". As it happens, on the basis of the logging in evidence, such as it is, the Respondent was logged in for the entire period. The Tribunal judged that the Respondent's words were neither false nor misleading. Thus, the allegation under Charges 3 a) and 4 a) was not made out and was dismissed.

29. In relation to Particulars under Charges 3b) and 4 b) falsely *stating that she had heard her client give evidence* what the Respondent said to the assistant coroner was "I could, I could hear my client, but I'm afraid I don't know what's happened since then". She was not asked; *did you hear every single word of your client's evidence?* If what is being alleged in b) is that the Respondent said, 'I heard all of my client's evidence' that is incorrect. When asked by the assistant coroner if she had any questions to ask, the Respondent replied, "I believe you covered everything Ma'am". The Respondent explained in her oral evidence, which the Tribunal accepts, that she had an iPad on which she had written down all the topics she wanted covered and all the questions she wanted asked. The Tribunal found that the Respondent honestly believed that she had heard her client give evidence. The Tribunal accepted the evidence of Dr Munro that it is more likely than not that she heard some or all of the evidence given by her lay client. It

followed that the allegation that the Respondent *falsely* stated that she had heard the evidence of HC was not made out and was dismissed.

30. In relation to Particular 3c) and 4c) the allegation is attempting to mislead the coroner by Claiming *that there must have been an Internet glitch* which impacted on her virtual presence. The Respondent did not say this on the 6 December. What she actually said was, "I've been on the link, I don't know if there's been a problem with the Internet, but no, I've been here. Let me switch on the lights just a minute", and then "I'm sorry I don't know if there was some sort of glitch, but I've certainly been on the link". Mr Welch dealt with this point by referring to the Respondent's witness statement and quoting the following: "there must have been an internet glitch"**.** In fact, what the Respondent said in her statement was "I knew I had not moved from my position and knew I had been sitting there in front of my laptop for a significant period of time. I was still trying to make sense of what was going on, ……and I could only deduce that it must have been down to an internet glitch." Even in the statement the Respondent was not *claiming* that there must have been an internet glitch. Moreover, the charge relates to what she is alleged to have said during the hearing on the 6 December, not what she said in a subsequent statement. Therefore, Charges 3c) and 4c) were not made out and were dismissed. Once again, it may be the case that the BSB over relied on the letter from the assistant coroner. If the BSB had checked the transcript carefully, it is likely that this last allegation would have been at least amended if not removed. The Tribunal found that the Respondent was genuinely confused and was trying to understand and explain what was happening. The Tribunal were satisfied that there was no attempt to mislead the assistant coroner whether knowingly or recklessly. Charges 3 and 4 were dismissed.

31. **Charge 5** as amended alleges breach of Core Duty 1 in that the Respondent *failed to observe her duty to the court and the administration of justice by failing to participate fully*. The Respondent admits that she failed to contribute effectively to the proceeding for at least part of the time but denies breach of Core Duty 1. Her defence, which applies equally to Charge 6, is that this was through no fault of her own; it was completely unintentional and was attributable entirely to her medical condition.

32. **Charge 6** alleges a breach of Core Duty 2 and Core Duty 7- *failing to act in the best interest of the client and failing to provide a competent standard of work* on the day in question. The Respondent admits that she did not meet the test of competence and that she did not act in the best interest of her client on that day, but denies her conduct amounted to breaches of Core Duties 2 and 7.

33. Mr Welch was invited to assist the Tribunal as to whether, if the Tribunal accepted the evidence of Dr Munro, the medical condition amounted to a defence or whether it would simply go to mitigation. Mr Welch contended that the medical condition, if proved, would be a mitigating factor relevant to sanction, but could not be a defence. Mr. Sheldon submitted otherwise and offered by way of analogy that if a barrister had a diabetic episode or an epileptic fit and was not able to conduct the work competently, no member of the public would say that the barrister had failed in their duties in a way that amounted to professional misconduct. The Tribunal were satisfied that, as a matter of fact, the Respondent's medical condition was the cause of her admitted failures under Charges 5 and 6 and that, as a matter of law, it amounts to a defence to both charges. Accordingly Charges 5 and 6 were dismissed.

34. The Tribunal wished to express its concern about the conduct of this case by the BSB. Once it was in receipt pho all the evidence, the BSB should have stood back and considered carefully whether it should pursue this case. The BSB had Dr Munro's first report in May 2023 and chose not to instruct its own expert; it had the second report in January 2024 and still chose not to instruct its own expert. The BSB did not check the transcript properly to see if the charges were properly framed. It is unfortunate and regrettable that this Respondent, who has an impeccable record at the bar and about whom senior members of the profession speak highly in respect of her integrity, her competence, and her commitment to profession, should have found herself charged with 6 serious professional misconduct allegations. That is particularity true of the allegations pertaining to dishonesty and lack of integrity. It is understandable that the assistant coroner was concerned because there was no immediate explanation, nor could there be,

for Respondent's behaviour on that day. Mr Sheldon has stressed that there can be no criticism of the assistant coroner. However, once the medical evidence was available, the BSB should have paused to reconsider the charges. To make matters worse, in the run up to her wedding the Respondent had these proceedings hanging over her, she had gone through a pregnancy with these proceedings hanging over her, and she had attended 2-day hearing having given birth just short of three months ago. At every step since 6 December 2022 the Respondent had done her best to understand and explain what happened and to seek and follow medical advice to avoid repetition. In short, she is beyond reproach.

**Dated: 22 August 2024**

**HH Janet Waddicor**

**Chair of the Tribunal**