Neutral Citation Number: [2019] EWHC 2357 (QB)

Case No: HQ18X02997

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 19/09/2019

Before :

MRS JUSTICE ELISABETH LAING

- -

Between :

DR MOHAMED AL-OBAIDI	**Claimant**
- and -	
FRIMLEY HEALTH NHS FOUNDATION TRUST	**Defendant**

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- -

MR JOHN CAVANAGH QC AND MR JEFFREY JUPP
(instructed by **IRWIN MITCHELL**) for the **Claimant**
MR MARK SUTTON QC AND MR LAITH DILAIMI
(instructed by **CAPSTICKS SOLICITORS LLP**) for the **Defendant**

Hearing date: 19 and 20 June 2019

- -

Approved Judgment

I direct that pursuant to CPR PD 39A para 6.1 no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

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MRS JUSTICE ELISABETH LAING :

Introduction

1. This is my decision on an application for a permanent injunction by the Claimant ('C'). The Defendant ('D'), C's employer, considers that C has a case to answer, for the purposes of a disciplinary hearing, about two charges. D's case is that C deliberately gave a misleading account of the management of patient DM by Dr Ali (a fellow consultant) in two ways.

    i. He made misleading comments in a statement of 1 July 2017.

    ii. He said that Dr Ali had told him on 19 January 2017 that DM had a coronary perforation.

2. D wishes to hold a disciplinary hearing at which D will consider whether those charges amount to gross misconduct. C wishes to prevent D from holding that hearing, on the grounds that the charges do not disclose a case to answer of gross misconduct, and that the disciplinary process is a breach of contract. C also argues that D's conduct of that process has destroyed any confidence he might have had in it. The events which are the subject of the charges happened in 2017, and for that reason also, C argues, D should be restrained from holding a disciplinary hearing.

3. C was represented at the hearing by Mr Cavanagh QC and Mr Jupp. D was represented by Mr Sutton QC and Mr Dilaimi. I am grateful to all counsel for their written and oral submissions.

The structure of this judgment

4. In this judgment I will consider

    i. the facts in outline (paragraphs 5-21)

    ii. the relevant law (paragraphs 22-48)

    iii. the material relevant to charge 8a (paragraphs 49-71, and 124-5)

    iv. the material relevant to charge 8b (paragraphs 72-107, and 126-134)

    v. the material relevant to C's main arguments about procedural irregularities

        1. the November 2018 investigation of D's IT systems (paragraphs 108-112 and 136-137)

        2. the involvement of Dr Haigh (paragraphs 113-121 and 138)

        3. D's reliance on the findings of the disciplinary panel in Dr Ali's case. This is linked with charge 8b, and I will consider them together (paragraphs 126-134)

        4. delay (paragraphs 122 and 139)

        5. bad faith (paragraphs 123 and 140-141).

The facts in outline

5. C is an experienced consultant interventional cardiologist. He was employed by D's predecessor as a Consultant in Cardiology and General Medicine on 24 July 2006. He was Clinical Lead in Cardiology from 2011 until October 2017. In his first witness statement he describes the steps he took as Clinical Lead to expand his department and to improve the service it provided.

6. Although there was a dispute about this on the pleadings, when I asked Mr Sutton in the course of his oral submissions, he accepted that C's written contract of employment, dated 24 July 2006, incorporated D's Disciplinary Policy and Procedure and the Policy and Procedure for Maintaining High Professional Standards for Medical Practitioners ('the MHPS').

7. DM died at 8.40 pm on 19 January 2017 at Wexham Park Hospital, Slough ('the Hospital'). Her death was caused by Dr Ali's mismanagement of a complication which arose in the course of a percutaneous coronary intervention ('PCI'). He should have realised that there was a complication and have stopped the procedure; and having failed at that stage to stop the procedure, should have realised a little later that the complication had got worse. He then failed to treat it appropriately. The contemporaneous evidence suggests that he considered that the patient had suffered a coronary dissection, whereas the complication was a coronary perforation. Two coronary perforations happened in the course of procedures conducted by Dr Ali that day, in the cases of DM and of SC. Dr Ali realised during the procedure that SC had suffered a coronary perforation. He treated her appropriately and she survived.

8. It seems that C and Dr Ali met after the operation on DM, about 3 hours before she died. The focus of D's disciplinary process is on discussion(s) between C and Dr Ali, and, in particular, on whether, as Dr Ali and C maintained, Dr Ali told C that DM had a coronary perforation, and on a report which C wrote about DM's case on 1 July 2017.

9. C relies on an exchange of text messages on 20 January 2017 between him and Dr Rex, another consultant cardiologist. It is convenient to describe that here. On 20 January 2017, Dr Rex texted C at 18.36. He said

> *'Mo. Did you hear about Omar's horrible case yesterday. Expect so but thought to make sure you were in the loop.*
>
> *Steve.'*

C replied

> *I heard about the patient with the perforation but I thought the patient was stable. Is this what you meant?*

Dr Rex then said

> *'She died last night'*

C responded

> *'Oh no…!'.*

Dr Rex's ended the exchange.

> *'I know. Omar saw relatives this morning I think. Lab staff all shaken. But ok. Texted Omar. Hope he is ok.'*

10. In his contemporaneous notes of the procedure, Dr Ali recorded that there had been a complication; a localised dissection of the artery. A dissection is a less serious complication than a coronary perforation. On 26 January 2017, Dr Ali presented the case at a multi-disciplinary team ('MDT') meeting as a perforation. He did the same at a Mortality and Morbidity ('M & M') meeting on 16 March 2017. However, in a Datix report (a report which is made about a serious incident) he recorded the complication as a dissection. He did the same in a statement he prepared for a coroner's inquest.

11. On 1 July 2017, C was asked to make a statement about Dr Ali's involvement in the care of DM. I say more about that statement below.

12. D has dismissed Dr Ali as a result of a separate disciplinary process. He was dismissed for giving dishonest accounts of his management of DM to D and to the coroner. C was not invited to give evidence at the disciplinary hearing in June 2018. The disciplinary panel ('the Panel') delivered its findings in Dr Ali's case on 12 July 2018.

13. The history of the disciplinary proceedings against C is recounted in detail in his witness statements and summarised in his counsel's skeleton argument. I say more about the contentious stages of that procedure below. At this stage, I merely summarise the process.

14. On 29 January 2018 Dr Ho, D's Medical Director, told C that he was to be investigated. There were seven allegations of misconduct. An eighth was later added. They did not relate to C's clinical practice. D decided on 3 June 2018 that there was a case to answer in respect of four allegations. On 20 July 2018, D said that none of the allegations amounted to gross misconduct. D refused to allow C to work at the Hospital. On 24 July 2018, C threatened to apply for an injunction. D then said that further information had come to light in relation to allegation 8. This was to become allegation 8b.

15. On 5 September 2018, Martin Spencer J granted C an injunction which required D to permit him to return to work at the Hospital. His view was that the four existing allegations (including what is now allegation 8a) did not amount to misconduct. He also considered that there was no realistic prospect that Mr Ireland would conclude that there was a case to answer in relation to allegation 8b.

16. C gave the case investigator, Mr Ireland, a statement about allegation 8b. Mr Ireland produced a first addendum report about allegation 8b.

17. In early November 2018, Dr Ho, Dr Umerah, D's Deputy Medical Director, and Ms King, D's Director of HR, carried out an investigation, which I say more about below. They discovered evidence which, in his cross-examination, Dr Ho frankly conceded, was relevant, and which C considers is 'powerfully exculpatory'. They did not disclose it to C. Mr Phillips, D's Cardiology Investigation Unit Manager, told C about it in November 2018 but C did not see the evidence until January 2019.

18. On 28 November 2018, D told C that it would not proceed with three of the allegations if C were to commit to structured 1:1 coaching and if this coaching were to be successful

in addressing the relevant matters. Dr Ho decided that he would involve an independent doctor, Dr Haigh, to consider whether or not C had a case to answer in respect of charges 8a and 8b. Dr Haigh was not told about the November 2018 investigation. Dr Haigh expressed his view on 17 January 2019 that there was a case to answer. He also suggested that D should see whether it was possible to tell who had looked at DM's angiographic images and when. Dr Ho told C by a letter dated 25 January 2019 that allegations 8a and 8b would be considered by a disciplinary panel.

19. On 29 January 2019 C's solicitors wrote a letter before claim to D. C said that he knew about the investigation in November 2018. D replied on 8 February 2019. C asked for information, D refused to give it, and C applied again on 19 February 2019 for an injunction to stop the disciplinary process.

20. On 27 February 2019, Dr Ho sent the material from the November investigation to Mr Ireland. Dr Ho suggested that this was new information sent by C, when, in fact, D had had it since November 2018. D agreed not to hold a disciplinary hearing until Mr Ireland had considered the November material and produced a report.

21. Martin Spencer J refused C's application for an injunction to restrain Mr Ireland from considering the November material. There was some delay. Mr Ireland produced a second addendum report on 5 April 2019. Dr Haigh expressed his views on it on 28 May 2019. On 31 May 2019, Dr Ho decided that there was a case to answer in respect of both allegations.

The relevant law

22. The parties now agree that the D's disciplinary procedure and the MHPS are incorporated in C's contract of employment. On the face of the relevant procedures, D would be entitled to hold a disciplinary hearing if D considered there was a case to answer that C had potentially been guilty of gross misconduct. C argues, however, that the Court can restrain D from holding such a hearing, on two broad grounds: there is no case to answer, and D has been guilty of serious and irremediable procedural errors.

23. There are two broad legal issues. They concern the approach which the court should take to the two grounds on which C seeks to restrain the disciplinary hearing.

(1) Who decides whether there is no case to answer, and how?

24. C's case is based in part on the decision of the Supreme Court in *West London Mental Health NHS Trust v Chhabra* [2013] UKSC 80; [2014] ICR 194. The employer in that case decided to hold a disciplinary hearing on the grounds that the claimant was guilty of gross misconduct because (among other things), while travelling on a train, she had been looking at a patient's confidential records, which were easily visible to other passengers, and because, on other occasions, she had dictated patient reports, including confidential information, while she was on a train.

25. Lord Hodge JSC, giving the judgment of the Supreme Court, described the role of the case investigator under the employer's policy D4, which implemented MHPS. The procedures did not give the case investigator the power to decide the facts. The aim of the policy is to have 'someone who can act in an objective and impartial way, investigate the complaints identified by the case manager to discover if there is a prima

facie case of…misconduct. The case investigator gathers relevant information by interviewing people and reading documents. In many cases the case investigator will not be able to resolve disputed issues of fact. He can only record the conflicting accounts of the interviewees and, where appropriate, express views on the issue'. Where there are admissions, or undisputed evidence, it is easier for the investigator make findings (paragraph 30).

26. The case manager was not bound by a perverse finding of the case investigator. Where a case investigator's report records evidence capable of amounting to misconduct, the case manager may convene a conduct panel. The case manager can make his or her own assessment of the evidence recorded by the case investigator in his report. The conduct hearing enables the practitioner to test the evidence in support of the complaint and any findings of fact by the case investigator (paragraph 31). In paragraph 32, Lord Hodge described the extent to which the procedure was flexible about the role of the case manager. He or she 'has discretion in the formulation of the matters which are to go before a conduct panel, provided that they are based on the case investigator's report and [associated materials, but he cannot] send to a conduct panel complaints which have not been considered by the case investigator or for which the case investigator has gathered no evidence'.

27. The Supreme Court, reversing the decision of the Court of Appeal, and upholding, in part, the decision of the first instance judge, held that the employer was responsible for four irregularities in its pursuit of the disciplinary proceedings, and that, cumulatively, those made it a breach of the contract of employment, and unlawful, for the employer to hold a disciplinary hearing. The employer therefore should be restrained from taking the procedure any further.

28. The first irregularity was the decision of the case manager that the conduct at issue could, on the evidence collected by the case investigator, amount to gross misconduct, because that evidence did not disclose a deliberate or wilful breach of patient confidentiality. That irregularity alone would have justified the grant of an injunction to restrain the employer from having the hearing (paragraphs 35 and 40). It and the third irregularity, 'in particular' were not minor irregularities, but were 'of a more serious nature' (paragraph 39).

29. The next most serious irregularity (but the third considered by Lord Hodge) was that the employer had broken an undertaking given by its solicitors to the claimant that a Mr Wishart would not be involved in the process. Contrary to that undertaking, the case investigator sent a draft of her report to Mr Wishart for his comments. He suggested extensive changes which made the report less favourable to the claimant, and the case investigator adopted some, but not all, of those suggestions. Lord Hodge explained that Mr Wishart's intervention went outside the agreed procedures (which had contractual force). It was legitimate for an employer to help a case investigator, for example by clarifying the report. Mr Wishart's intervention went beyond that. The report had to be the work of the case investigator; and the breach of the undertaking was a breach of the obligation of good faith in the contract of employment. It was not a minor irregularity (judgment, paragraphs 37 and 40). It was 'of a more serious nature' (paragraph 39). Lord Hodge did not say whether this irregularity would, alone, have justified the grant of an injunction.

30. The second irregularity considered by Lord Hodge was that the case manager relied on a version of the policy that was not in force at the material time. There was a non-exhaustive list (in force at the material time) of typical examples of misconduct (paragraph 36). That irregularity would not, on its own, have justified the grant of an injunction (paragraph 40).

31. The case manager had decided in a letter dated 12 August 2011 that the then complaints were capable of amounting to gross misconduct. The fourth irregularity identified by Lord Hodge was that the case manager did not re-assess that decision in the light of the case investigator's second report, which concluded that there was no case to answer on one of complaints on which the case manager had relied in making the decision of 12 August 2011. The policy obliged him to reconsider whether the remaining complaint could amount to gross misconduct and he did not do so. An objective observer would not consider that to be reasonable (paragraph 38). Lord Hodge had 'some doubt' whether if that had been the only complaint, it would, in the circumstances, have justified the grant of an injunction (paragraph 40).

32. There is no discussion in Lord Hodge's judgment of the test which the court is to apply when faced with a dispute about whether conduct is capable of amounting to misconduct for the purposes of a policy which implements MHPS. He simply stated, in paragraph 35, '…I do not think that the findings of fact and evidence [in the investigation report], were capable, taken at their highest, prima facie supporting a charge of gross misconduct'. This language suggests that Lord Hodge assumed that it was for him to decide whether or not there was misconduct. I infer, however, from the lack of discussion of this point in the judgment that there was no issue in *Chhabra* about the test which the court should apply when considering whether or not to grant an injunction on the basis that conduct which a case manager proposes to refer to a disciplinary panel is not capable of being misconduct. I do not, therefore, consider that *Chhabra* can help me to decide what the correct approach is.

33. Mr Cavanagh also relied on the decision of the House of Lords in *Skidmore v Dartford and Gravesham NHS Trust* [2003] UKHL 27; [2003] ICR 721. The issue in that case was whether the conduct of which an employer accused an employee was 'personal conduct' which, under the contract of employment, was to be dealt with internally by the employer, or 'professional conduct', which had to be dealt with by an external panel with a legally qualified chairman. Under the contract, the employer had to decide to which category the conduct belonged. The employee was dismissed after the employer chose the 'personal conduct' procedure. His claim for unfair dismissal failed but succeeded on appeal to the Court of Appeal. The House of Lords upheld that decision. The House of Lords held that it was for the employer to choose which procedure to use, but that that decision should be made in accordance with the terms of the contract. If a decision was made which was not in accordance with the terms of the contract, the employee was entitled to remedies for breach of contract, in the absence of an express term providing that the decision about category would be made in good faith and on reasonable grounds. There was no warrant for implying such a term, as judges had done in two of the cases considered by the House of Lords (per Lord Steyn, at paragraph 16).

34. The employer had used the wrong procedure. The claim was remitted to the Employment Tribunal for it to decide, on the basis that the employer had used the wrong procedure.

35. *Skidmore* was followed and applied to the decision of a case manager whether there was a case to answer under the defendant Trust's disciplinary procedures by Jacobs J in *Ardron v Sussex Partnership NHS Foundation Trust* [2018] EWHC 3157 (QB), [2019] IRLR 233 at paragraph 73. It is not clear from that report whether Jacobs J was referred to the case which I mention next. It appears not, because he recorded, at paragraph 69 of his judgment, that there was no dispute about the relevant legal principles.

36. Mr Sutton relies on *Braganza v BP Shipping Limited* [2015] UKSC 17; [2015] ICR 449. That case concerned the entitlement of the claimant, the widow of an employee, to a death-in-service benefit. The employee had disappeared from the deck of the vessel he was working on. He was declared lost overboard, presumed drowned. The second defendant investigated and decided that the most likely explanation for his disappearance was that he had committed suicide, rather than that he had fallen overboard by accident. If he had committed suicide, no benefit was payable to the claimant.

37. The Supreme Court held that when a contract gives a party to it power to exercise a discretion or to form an opinion about relevant facts, it is not for the court to make the decision for the party to the contract. Where, however, a decision could affect the rights and obligations of both the parties and there was a conflict of interest, the court would, in appropriate cases, imply a term that the power should be exercised in good faith, and rationally (in the public law sense).

38. The majority of the Court held that the discretion had not been exercised in accordance with that implied term, because the employer had not directed itself that suicide was so inherently unlikely that a finding of suicide could not be made without cogent evidence, and the evidence and findings of the investigation were not cogent enough to justify the employer's conclusion that the employee had committed suicide. The decision could not stand, and the employee's widow was entitled to the benefit.

39. The question for me at this stage is whether C has a contractual right not to be exposed to a disciplinary hearing unless there is, as a matter of law, a case to answer, or whether it is necessary to imply in the contract a term that the case manager's discretion to refer a case to a disciplinary hearing will be exercised in good faith and rationally.

40. The decision of the case manager under MHPS involves an assessment of a question of fact (whether there is prima facie evidence to show something), a mixed question of fact and law (whether that evidence discloses conduct which is capable of amounting to gross misconduct), and a further discretionary question (whether it is appropriate in the circumstances to hold a disciplinary hearing). I am inclined to think that three-fold discretion is analogous to the employer's contractual discretion in the *Braganza* case to decide whether an entitlement to death in service benefit was excluded by the employee's suicide.

41. In other words, this is a situation in which it is necessary to imply a term in the contract of employment that the discretion to decide whether there is a case to answer is to be exercised in good faith, and rationally. The contract confers the discretion on the case manager, and the court reviews the exercise of the discretion to see whether it has been exercised rationally and in good faith. The court will only interfere with his decision if

he has broken the implied term which governs the exercise of his contractual discretion; that is, if his decision is made in bad faith, or is irrational in the public law sense.

42. However, I do not consider, on the facts of this case, that it makes any difference whether this is a *Skidmore* or a *Braganza* case. I will therefore assume that the question I have to answer is whether the findings of fact and evidence in the investigation report were capable, taken at their highest, of supporting, prima facie, a charge of gross misconduct. I will also indicate whether a reasonable decision maker could have concluded that they did.

(2) *What is the relevance of procedural errors?*

43. C submits that D has an implied duty to act fairly. C submits that *Chhabra* shows that the cumulative effect of procedural irregularities and unfairness can justify the grant of an injunction to restrain disciplinary action.

44. D does not accept that there is a free-standing contractual duty to act fairly. D submits, rather, that acting fairly is an aspect of the implied duty of trust and confidence. A court will not restrain disciplinary action unless there has been a breach of that implied term. Whether that term has been breached, therefore, is to be tested by the criteria in *Malik v BCCI* [1998] AC 20. That is, the conduct must be such as, without reasonable and proper cause, is apt to destroy, or seriously to undermine, trust and confidence. In other words, disciplinary action will not be restrained unless the employer's conduct was (or will be) a repudiatory breach of the contract of employment.

45. One of the issues considered by the Supreme Court in *Chhabra* (which I have considered in paragraphs 24-33, above) was what type of procedural irregularity will justify the grant of an injunction to restrain disciplinary action. In summary, Lord Hodge said that the irregularities in that case cumulatively made it a material breach of Dr Chhabra's contract of employment for her employer to convene a conduct panel (paragraph 34).

46. The incorrect finding of case to answer was enough on its own to justify an injunction. Lord Hodge described the third irregularity (which was a breach of an express undertaking) as a breach of contract, specifically, of 'the implied term of good faith'. It is not clear whether by that he meant the duty of trust and confidence. An objective observer would not have considered it reasonable, he added. Dr Chhabra had an implied contractual right to a fair process. Mr Wishart's involvement undermined that (paragraph 37). The fourth irregularity was a breach of terms of the relevant procedure and an omission which an objective observer would have considered unreasonable (paragraph 38).

47. Minor irregularities are not sufficient (paragraph 39). Something 'more serious' is required (ibid). Lord Hodge did not describe the irregularities in the *Chhabra* case as repudiatory breaches of the contract of employment.

48. It seems, therefore, that to justify the grant of an injunction, either on its own, or cumulatively, a procedural irregularity must be sufficiently serious. It seems that it must also be a breach of an express or implied term of the contract, but that it need not be a repudiatory breach.

The disciplinary charges

(1) Charge 8a: 'You deliberately provided a misleading account of the management of DM…in order to support an inaccurate statement by a consultant colleague in particular by a) providing misleading comments in your statement of 1 July 2017 as outlined on page 38-39 paragraphs (a)-(e) of Mr Ireland's report'

(a) C's statement made on 1 July 2017

49. In cross-examination C explained that he was writing this report for doctors who were not specialists in cardiology. That was why he explained the Ellis Classification grades I-IV, even though grades I-II were not directly relevant (he gives a footnote to an academic paper on this topic).

50. I now summarise that report. C says that angioplasty was appropriate. There was some difficulty pre-dilating the lesion with a balloon. That was achieved with a 3.0mm balloon. A 4mm stent was then inserted. C opines that the size of the stent was appropriate, as 'evidenced by post-deployment images'. If it had been too big that would have been obvious on the images. An area within the stent looked slightly under-deployed. C opines that 'it is well within the normal practice to "post-dilate" segments of the stent using a larger balloon to ensure a good apposition of the stent to the vessel wall'. He says that it is also 'customary to use a balloon that is 0.5mm larger than the stent, 'which Dr Ali has done'.

51. The report continues, 'Arguably however and with hindsight the use of a 4.5mm balloon in this case could have been avoided. Following the inflation of the 4.5mm balloon there was a local perforation', which is 'a recognised and potentially life-threatening complication of the procedure and is presumed to occur around 0.5% of the time'. C then describes the various degrees of coronary perforation, and gives a reference in a footnote to a paper about this. He says that grades I-II are classed as "dissection" without extravasation and grades III-IV are 'when the vessel wall is compromised leading to extravasation of blood "contrast" and the latter are the ones we would customarily class as "coronary perforation".'

52. The technique for managing a perforation, especially grades III-IV, C says, varies among practitioners. There is also controversy about whether anti-coagulation should be reversed or not. 'Regardless of the variations the primary objective would be to stop' the bleeding, and, where necessary, to drain the pericardium. C says that 'Dr Omar Ali has informed me that he recognised the "perforation" as a potential grade III'. He used a balloon tamponade to stop the bleeding. 'Unfortunately there was no angiographic documentation at the end of the procedure to show whether the perforation was sealed'. Dr Ali also told C that the patient had no symptoms at all and stable blood pressure and pulse. He therefore decided to discharge the patient to the ward.

53. Under the heading 'Post Procedure', C recounts that he was not in the cathlab at the time of the procedure but that Dr Ali spoke to him in his office on the same day. '…he was quite explicit in saying that there was a complication in the form of coronary perforation. He also assured me that he had dealt with the situation by balloon tamponade and by the end of the procedure the patient was completely well…' She had no symptoms and stable pulse and blood pressure. Dr Ali explained that he had not done a transthoracic echo in the lab because of the patient's condition, but had asked for it to be done 'urgently on the ward'.

54. C says that there were no other issues to his knowledge and reports the nurses' accounts that the patient was 'completely well'. They were thinking of discharging her, but Dr Ali had advised that she stay until the next day. C discovered, when he arrived the next day, that the patient's condition had deteriorated and that she had died. Everyone was upset but it was not clear what had happened.

55. At the MDT meeting, 'we went through the images and the treatment and again it was quite clear that the situation was coronary perforation and Dr Omar Ali was quite certain in describing it as such'. The MDT meeting was critical of the failure to show images at the end of the procedure 'to confirm that the bleeding has stopped', and of the lack of an echo, which should have been done in the lab, or shortly after discharge to the ward. There was a delay in getting the post-mortem result. The case was 'eventually' discussed at an M & M meeting on 16 March 2017. The findings 'were in keeping with pericardial tamponade secondary to coronary perforation'. The case was thoroughly discussed. There was no doubt among those present, including Dr Ali, that it was a case of coronary perforation.

56. They acknowledged that the patient's stability had been deceptive. One of the learning points was that the patient should have been nursed in the coronary care unit, not in the recovery bay. The other 'important learning point' was that there should have been early and repeat echos. The third was that 'assurance' that the perforation had been controlled 'should have been obtained' by imaging before the patient was discharged from the lab. There was 'no other major concern'. The case had by then been referred for a serious incident investigation. C 'obviously eventually' knew that there was to be an inquest. As far as he was concerned 'from a governance prospective [sic] I was happy that all appropriate processes had taken place'. C was happy for this and other complications in the cathlab to be investigated 'in an open manner'.

57. C then said that 'Unfortunately however it appears there was a problem with this particular case in that Dr Ali in his report in the cathlab had stated that the complication was a coronary dissection rather than a coronary perforation. Up to that point I had not been aware of this statement however neither myself nor any of my colleagues had at any point felt that Dr Ali was trying to hide, mask or cover up the complication he has encountered. As far as I was concerned Dr Ali had been open and has discussed this case with myself and others in open multi-disciplinary forums. I however have no explanation as to why in the report he has put down the complication as a coronary dissection and not a perforation.'

(b) Dr Gunning's comments

58. On 16 August 2017, Dr Gunning wrote to Dr Ho, who had asked him to do an independent review of DM's case. I now summarise Dr Gunning's views. A significant flow-limiting lesion was found on 9 December 2016. DM was referred for a PCI. Dr Ali did this on 19 January 2017. The procedure started at 09.55 and ended at 10.34. DM was given heparin. Pre-dilatation was done with a 2.5mm and then a 3.5mm compliant Trek balloon to high pressure. The lesion was resistant and calcified. A 4x38mm stent was used and post dilated with a non-compliant Trek balloon to 4.5mm up to a pressure of 14 atm. The operator commented that a localised dissection was seen but the patient reported no chest pain and no ECG changes were seen. Pulse and blood pressure were stable. The equipment was removed. The plan recorded at that stage was for DM to be

discharged that day. Dr Ali reviewed DM at 19.30. She was feeling comfortable with no chest discomfort.

59. She suddenly became short of breath at about 20.05. She lost consciousness quickly. Her blood pressure went down, and her pulse increased. She quickly had a heart attack. She died despite attempts to resuscitate her. The key post-mortem finding was extensive bleeding in the anterior wall of the left ventricle arising from a rupture of the artery in which the stent had been used. There were 200ml of blood in the pericardium. The cause of death was cardiac tamponade related to dissection of the relevant artery.

60. Dr Gunning considered that the referral for a PCI was appropriate. He agreed that there was a long calcified lesion affecting 70-80% of the luminal diameter of the artery. Beyond the lesion the vessel was between 2.75 and 3mm wide. The width just near the lesion was 3.5mm at most. The choices of wire and catheter were appropriate. The initial use of a 2.5mm balloon was appropriate. The operator chose a 3.5mm balloon for a second series of balloon pre-dilatations. That was larger than the size of the vessel in the further reaches of the diseased part of the artery. A different method could have been used to reduce the calcified segment. The inflation of a smaller non-compliant balloon of 3mm or less, or a scoring balloon, again smaller than 3mm, or rotational atherectomy were good options. None was used.

61. The operator then used a 4x38mm stent in the vessel where the nearest dimension was 3.5mm and the furthest, about 2.75mm. The stent was too large for this artery. It was used at very high pressure (20 atm). On the images after the use of the stent there is clear dye-staining in the lower side of the stented section. There is a clear indication of injury to the wall of the artery, but the dye is not escaping quickly. This is classified as an Ellis type II coronary perforation. From the procedural record, the operator failed to recognise this early sign of coronary perforation.

62. The operator then post-dilated the stent using a 4.5mm non-compliant balloon to high pressure. This, says Dr Gunning, was ‘a significant error’. After the balloon was inflated, ‘significant deterioration in the imaging features is seen’. There is clear leaking of dye from the artery on the lower side of the stent which is ‘highly likely’ to be bleeding into the myocardium with residual dye staining following the injection. Dr Gunning describes this as ‘Ellis type III coronary perforation’. The operator failed to recognise this, but referred to it as a localised dissection. ‘This was a significant error’. The guide wire was removed. A further image shows persistent leaking from the vessel which is likely to be going into the myocardium and the pericardium. ‘This was an error and there was a clear failure on the part of the operator to recognise the…coronary perforation to institute appropriate management’.

63. Dr Gunning made five recommendations for better management of this case.

    i. The pre-dilatation balloon should not have been bigger than 3mm. More advanced balloon technology might have been used to reduce the calcified material in order to avoid such high-pressure inflation.

    ii. The wrong stent size was chosen. The 4mm device was bigger than the artery, and that, with the 3.5mm pre-dilatation, led to the first signs of coronary perforation.

iii. Once the artery had perforated, the wisest course of action would have been to stop the procedure and carefully to observe DM. An echo should have been done immediately in the cathlab to check for a pericardial effusion. Observation should have continued in the cathlab recovery area and the ward. The plan to discharge DM that day was not appropriate. 'Fastidious observation' should have continued overnight. It is likely that without further balloon dilatation, DM would have settled with conservative management.

iv. The use of the 4.5mm balloon was flawed. It made an existing coronary perforation worse. When there is clear leaking, management should include a repeat low-pressure inflation with a compliant balloon in the stent. That seals the leak and allows further assessment. An immediate echo in the cathlab would be recommended. The reversing of the heparin should have been considered. A covered stent could be used to seal the rupture.

v. The perforation should have been identified. The ward staff should have been told about it. Discharge the same day with this complication is never appropriate.

64. Dr Gunning explained that coronary perforation is a recognised complication of PCI. It happens in about 0.6% of cases. In many cases it is benign, but where there is brisk leakage (Ellis type III) a bad outcome is more likely. Where it is followed by cardiac tamponade, the risk of death is close to 50%. 'It is essential to recognise and manage this complication. It is an expected standard of care for a qualified interventional cardiologist'.

65. In an email dated 20 April 2018, Dr Gunning commented further on C's case. Dr Gunning said that C was wrong to say that coronary perforation is often referred to as coronary dissection. He 'strongly disagree[d]' with C's suggestion that the stent and balloon size were appropriate for the vessel. Any ten experienced interventional cardiologists would also disagree. Dr Gunning disagreed with C's views that using a non-compliant balloon 0.5mm larger than the stent is usual practice, and was appropriate in this case. An increase in size is only appropriate if the original device was too small and it is under-deployed. The cardinal error was failing to see the limited 'dissection' after the stent was first used (Dr Gunning agreed in an email sent on 23 April 2018 that he meant 'perforation' here; the final draft of his comments corrects this). 'The stent was already too large. To then add insult to that vessel injury by using a bigger balloon, thus further traumatising the damaged vessel is foolhardy at best. It proved to be catastrophic.'

66. Dr Gunning said that C supported Dr Ali's retrospective claim that he recognised the coronary perforation and treated it appropriately by a prolonged balloon inflation to try and seal the leak. Dr Gunning challenged that. The procedure notes and the procedure record do not use the term perforation. There is no record of prolonged balloon inflation in the notes, or in the procedure report. No digital x-ray shows that. That is unheard of, as the inflation would have to be continued for five or ten minutes. He had just looked at the films again. They did not show any balloon inflation after the inflation of the 4.5mm balloon in three different positions, which was followed by the frank perforation. The wire was removed. The final shot still shows the perforation, not

recognised by the operator. Whether the assertion about the prolonged balloon inflation (which Dr Gunning did not believe) was true could be checked by looking at the records of the technician/physiologist in the cathlab. They usually record details of each balloon or stent inflation.

(c) C's statement dated 25 April 2018

67. C commented on Dr Gunning's email in a statement dated 25 April 2018. He disagreed that he had suggested that a perforation is often referred to as a dissection. He had not said this and did not believe it to be the case. He did not understand the relevance of the discussion of Ellis types. He accepted that he had not criticised the size of stent, but he had said that 'arguably…and with hindsight the use of the 4.5mm balloon could have been avoided'. His view of the stent size was his 'opinion as a senior interventional cardiologist, honestly given'. He disagreed with Dr Gunning about whether it is usual practice to use a post-dilatation noncompliant balloon that is 0.5mm or sometimes 1.0mm larger than the stent. It was his practice and that of many other interventional cardiologists. In any event, he did not imply or suggest that the use of the post dilating balloon was appropriate for DM; in fact 'the opposite'; he had said that 'arguably and with hindsight' it could have been avoided.

68. He was disturbed by Dr Gunning's suggestion that he had supported Dr Ali's claim, or his actions during or after the procedure. There was no basis for that. C was simply conveying what Dr Ali had told him on the day of procedure and then at the MDT and M & M meetings. He did not dispute that there were no images at the end of the procedure to confirm that the leak had been controlled. Dr Ali was challenged about that at the MDT and M & M meetings. He had highlighted that by noting that, unfortunately, there were no relevant images, and that Dr Ali had been criticised about that.

69. The context in which he had given the statement was important, he said. After Dr Ali's initial interview on 22 June 2017, 'there was clearly a misleading account by Dr Ali'. Dr Umerah rang C and said that he was concerned that Dr Ali was claiming that the complication was a dissection. That was the first time C had ever heard that word in this case. He told Dr Umerah so. He asked Dr Umerah if he could speak to Dr Ali. He was astonished to find out that Dr Ali had described the complication as a dissection in his procedure report. He asked Dr Umerah to arrange a second meeting with Dr Ali on 26 June. Dr Umerah then asked C to provide a statement 'largely to provide an account of mine and everyone in the department's perception of how Dr Ali reported the complication to us and in particular whether at any point Dr Ali has described the complication to us as a dissection. He did not refer to the hospital notes when preparing his statement, but, on 22 June, Dr Ali for the first time showed C the procedure report. 'I had already seen the angiographic images'.

70. He was very disturbed by the allegation that his statement was in any way misleading. Everything was a true account of what he was told by Dr Ali.

(d) Mr Ireland's approach

71. On 3 May 2018, Mr Ireland produced a report into the concerns about C which were described in Dr Ho's letter of 29 January 2018. He reviewed the evidence he had

gathered on pages 32-37 of his report. His findings were at pages 37-39. He found that there were five concerns to answer about this allegation and C's report of 1 July 2017.

a. C's statement that he and his colleagues had had no concerns that Dr Ali was trying to hide or cover up the complication. C had told Drs Jewsbury and Umerah that he had asked Dr Ali what he was doing, why he had written dissection and that that was wrong. C did not remember why Dr Ali had recorded the complication as a dissection. In the light of that, C's comment in the report was 'unfortunate', particularly given Dr Gunning's view that Dr Ali had treated the complication as a dissection and not as a perforation. C knew when he wrote his report that Dr Ali had written in the coroner's report that he had recorded the complication as a dissection. He also knew that Drs Jewsbury and Umerah were unhappy with Dr Ali's explanation.

b. Staff in interviews described C as forthright. The report did not come across in that way, especially as regards the post-dilatation balloon ('arguably…). Dr Gunning's view was that 'there was no arguably about it'. It seemed that C could have been 'more forthright' in his report.

c. When Mr Ireland asked him, C's responses about his view about the size of the stent was that that was his view as an expert. The other experts who had reviewed the procedure commented on the size of the vessel. C did not. Mr Ireland was not a clinician, but it did seem to him that reference to the size of the artery would have undermined the comment that the stent was the right size.

(2) Charge 8b: ''You deliberately provided a misleading account of the management of DM…in order to support an inaccurate statement by a consultant colleague in particular by b) stating that [Dr Ali] told you on 19 January 2017 that he had had two patients who sustained perforations that day when in fact [Dr Ali] could only have informed you that he had had one perforation in relation to patient SC. Despite what you have stated, [Dr Ali] did not mention that patient DM had sustained a perforation during any conversation with you on that date'

(a) Mr Ireland's addendum report of 11 October 2018

72. Mr Ireland explained that C had been sent a redacted copy of the outcome letter in Dr Ali's case. His addendum report was based on a review of the conclusions of the disciplinary panel ("Panel") in Dr Ali's case, and other related materials. Mr Ireland also considered the judgment of Martin Spencer J dated 5 September 2018, and, in particular, paragraphs 61-68. Mr Ireland noted that the Panel had concluded, in Dr Ali's case, that he had treated the complication in DM's case as a dissection and not as a perforation, and had then sought to cover that up. He had taken into account the text exchange between C and Dr Rex, which C claimed supported his version of events. Mr Ireland's view was that the texts were inconclusive. A further email from Dr Rex seemed to support management's argument in Dr Ali's case (see paragraph 76, below).

73. Mr Ireland said that there was thus an apparent conflict between C's evidence (that Dr Ali had told him on 19 January that he had treated DM as a perforation) and the conclusion of the Panel, that Dr Ali could not have done this, as he treated DM as a dissection and was not aware that DM had a perforation until after 19 January. If the Panel's conclusions were correct, they raised questions about C's statement to Dr Jewsbury that Dr Ali told him on 19 January 2017 that he had treated DM as a perforation.

74. The Panel had concluded that in DM's case, Dr Ali thought he was dealing with a dissection and not with a perforation. Dr Ali visited DM at 19.30. She had a heart attack at 20.05. Dr Ali was not there and was told the next day. Dr Ali said that he had told C that he had treated DM as a perforation on 19 January and C said the same thing. The Panel had a statement from C (probably that given to Mr Ireland on 6 April 2018) that that Dr Ali had told him on 19 January 2017 that DM had had a perforation and that there had been another that day. The Panel's view was that if, as they had found, Dr Ali did not recognise that there was a perforation, it was difficult for them to accept C's statement that Dr Ali had told him on 19 January that he had treated DM as a perforation.

75. In paragraph 3.2 of the addendum report, Mr Ireland considered the nine factors on which the Panel's conclusions were based.

i. The nurses who were present during the procedure wrote down that there had been a dissection, because that is what they were told. Nurse Hill wrote, 'Slight dissection no treatment needed'.

ii. The conclusion of the cathlab report was 'localised dissection noted'.

iii. Julia Hollywood said that Dr Ali inflated the balloon for 30 seconds to 2 minutes. Ellis guidance for this type of perforation is that the balloon should be in place for 10 minutes. Dr Clarkson (who gave evidence to the Panel) had said that the balloon had not been inflated for long enough.

iv. Additional heparin was given at the end of procedure. That was at odds with a diagnosed perforation. Dr Clarkson said that he would have reversed the anti-coagulation.

v. The Panel felt that if a perforation had been diagnosed, the mood in the cathlab would have changed, as a perforation is a life-threatening complication.

vi. Dr Clarkson said that what was recorded was fairly standard for a dissection. Nothing suggested a perforation.

vii. Dr Clarkson said if there was perforation, DM should not have been taken off the table until an echo had been done.

viii. Dr Clarkson said that perforations were rare and serious. The Panel concluded that a perforation would have required DM to stay overnight, yet Dr Ali had said that she could go home if she was stable.

ix. The Panel found Dr Clarkson's evidence compelling.

76. Mr Ireland said that the Panel included people who would understand the technical issues. The evidence they had considered, and their conclusion, suggested that Dr Ali treated DM as a dissection and not as a perforation. Dr Rex, another experienced interventional cardiologist, who was on duty in the cathlab on 20 January, looked at the images for DM that day and identified a clear perforation. He showed the staff, and none had been aware of it; it was not mentioned in the report. It was news to all the staff he spoke to. Dr Rex also said that an echo had not been requested. That was a mandatory minimum in a perforation case. There had been another clearer case that

day, said Dr Rex, and maybe wires were crossed. Dr Rex was not called by either side at the Panel hearing, but his views seemed to support the conclusions of the Panel.

77. Mr Ireland summarised C's statement responding to the outcome letter in Dr Ali's case. C was surprised by the finding of the Panel. He was astonished that he had not been called to give evidence. He would have produced the exchange of texts between him and Dr Rex. In C's view, those texts showed clearly that C knew that DM had a perforation. The only way he could have known was because of his conversation with Dr Ali on 19 January, who told him that he had had two perforations that day. The text message was clearly about DM as she was the patient who was stable and who later died. The suggestion that Dr Ali did not know that he was dealing with a perforation is wrong. 'Had this been the case Dr Rex would have corrected [C] to say that it is not the patient with the perforation who had died it was the one with the dissection. This did not happen'.

78. In paragraph 3.4, Mr Ireland considered the text messages. C felt that the exchange proved that he had a conversation with Dr Ali the day before. Mr Ireland noted that the messages did not refer to any patient by name. There were two perforations that day. C had heard about 'the patient' (singular) with 'the perforation' (singular). He might have responded differently had he known that two patients had perforations. C did not ask which of the two had died, which might be expected. Mr Ireland considered it more likely that C would have asked this question if he only knew about one patient with a perforation. By 18.36 on 20 January (the time of the text) DM's death was widely known in the team. Dr Rex showed the images to staff on 20 January and those came as news to them. C said that the text showed he was referring to DM because he knew that DM was stable. Mr Ireland had examined DM's and SC's notes and discussed them with Dr Clarkson. DM certainly appeared stable. SC's perforation was dealt with appropriately. By 17.00, both patients were stable. In his response to the outcome letter, C said that SC had a more profound reaction to the perforation than did DM, yet, said Mr Ireland, in his text, C claimed that he was referring to DM. But if C had been told on 19 January that there were two perforation cases, and had been told the next day that one had died, it is a reasonable assumption that the patient in the more complex case had died.

79. Mr Ireland did not find that the text messages proved that Dr Ali and C had a conversation on 19 January. The fact that only one perforation is referred to was a concern. Mr Ireland considered C's response (see the last sentence of the last paragraph but one). By the time he sent the text, Dr Rex knew that DM had had a perforation. He would not, therefore, have corrected C by saying that it was the patient with the dissection who had died.

80. Mr Ireland reviewed the work rotas to see if it was possible that C and Dr Ali had had a conversation on 19 January. These did not rule out a meeting between them. C's account was that he returned to the site at about 5pm, and that Dr Ali told him about 2 perforations. Dr Ali's recollection was somewhat different. He thought that he had discussed the two cases with C in two different meetings. The fact of a meeting or meetings did not help with what was discussed at the meeting/s.

81. Mr Ireland considered that two perforations on the same day must be rare, yet C as clinical lead did not report them to anyone. C told Mr Ireland that he had no clinical concerns about Dr Ali. If C had reported two perforations that day it would have

supported his account. Dr Rex said that an echo was a minimum requirement with a perforation. If C had asked Dr Ali to do an echo, Mr Ireland considered that he would have followed that up with Dr Ali the next day. He seems not to have.

82. Mr Ireland then considered the judgment of Martin Spencer J. Mr Ireland had information that Martin Spencer J did not have: the Panel's findings in Dr Ali's case, he had reviewed the notes of both patients, he had received new information from Dr Rex, and he had seen the text exchange on 20 January (I note, however, that Martin Spencer J considered this material: judgment, paragraph 65).

83. Mr Ireland concluded (section 4) that there was an apparent conflict between the evidence of C and the conclusions of the Panel. He described that conflict. In essence, if Dr Ali did not realise that DM had a perforation, he could not have said that he did to C. If the Panel's conclusion was correct, C's evidence about the conversation with Dr Ali on 19 January could not be correct. Mr Ireland had reviewed the evidence which led the Panel to conclude that Dr Ali treated DM as a dissection. That conclusion seemed reasonable. Dr Rex's emails also appeared to support that conclusion. C relied on the text message but it could be read as showing that C only knew of one perforation at the time.

84. Mr Ireland asked himself whether some other explanation of events was possible, for example whether Dr Ali lied to C on 19 January. The weight of the evidence suggested that Dr Ali did not know of a second perforation on 19 January. Dr Ali could have misled C later, but C was adamant that the conversation was on 19 January, and that he was told of two perforations then. 'However it appears that this could not be the case'. Mr Ireland said that he had considered material which was not available when he wrote his first report, and so could not be reviewed by him or by Martin Spencer J. The evidence supported 'the concern that [C's] statement that he was told about the two perforations on 19th by Dr Ali could not be correct'. There was 'compelling evidence' that Dr Ali considered that DM had suffered a dissection not a perforation at that time of the procedure, and that he did not know she had suffered a perforation until the next day. It was therefore implausible that C and Dr Ali could have discussed DM's perforation on 19 January. The text message did not show that the discussion must have been as C described it. There were other explanations.

(b) Dr Haigh's letter of 17 January 2019

85. Dr Haigh sent Dr Ho a letter dated 17 January 2019. His conclusion was that a disciplinary hearing was appropriate. He thought it unlikely, on the balance of probability, that during the conversation or conversations between Dr Ali and C sometime after 17.00 on 19 January 2017, they discussed two cases of coronary perforation. He listed the eight factors he had taken into account in reaching that view. He considered that C had a case to answer because there was a possible conflict between C's statements that two cases of perforation were discussed on 19 January and the statement later made by Dr Ali, in which previously incorrect information provided to the Defendant and the coroner was corrected. Dr Haigh did not believe that a practitioner would submit a diagnosis of dissection to a coronial inquest unless he thought the diagnosis was correct. If the disciplinary process concluded that C provided misleading information about his discussion with Dr Ali, that could be gross misconduct.

(c) C's comments on the addendum report

86. On 28 October 2018, C commented on Mr Ireland's addendum report. He did not accept the factual accuracy of the report. It was 'yet another attempt' by Mr Ireland and Dr Ho 'to secure evidence against me in a partial and biased manner'. Martin Spencer J considered the allegation that C had provided a misleading report. He had the Panel's conclusions, the text messages, and knew that there were two perforation cases that day. Martin Spencer J's 'ruling is clear and unambiguous that there was no evidence to support [the Defendant's] allegation that my statement was in any way misleading'.

87. The majority of the staff mentioned by Dr Rex were nowhere near the cathlab or the coronary care unit on the Thursday. It was unsurprising that they did not know about the case or about any complications. A junior trainee could tell from the images that DM had a perforation. It was clear from Dr Rex's exchange with Mr Ireland that he knew that there were two perforations. That was 'hugely important' as it confirmed that they were thinking about the same patient in the text exchange. It was obvious to both of them that they were talking about the same perforation case. Dr Rex referred to the other case as being a much clearer case. Dr Clarkson's views about the stability of SC were wrong (paragraph 11).

88. In paragraph 12, C accepted that, had he suspected any wrongdoing at the time, he might well have reported the two perforations. However complications, while rare, do happen. In three years, he had never previously had any concerns about Dr Ali's work. His account was given in good faith. He had no idea why Dr Ali wrote in the report that it was a dissection, submitted a Datix to that effect in April 2017, a report to the coroner, and tried to convince Drs Jewsbury and Umerah on 22 June 2017 that it was dissection.

89. C found it 'frankly disingenuous' that Mr Ireland did not think that the text 'necessarily' supported C's case. He continued to rely heavily on the findings of the Panel. C was not asked to contribute to those. Martin Spencer J described them as 'flawed'. Mr Ireland's conclusions were based on speculation and conjecture, rather than facts, because there were no facts to support the allegation. He had no appreciation of the timescale. C was being asked about a report he submitted 16 months ago in relation to a conversation which happened 21 months ago. Mr Ireland's conclusions were an act of defiance to an explicit High Court judgment.

(d) Further correspondence

90. Dr Ho sent a letter dated 25 January 2019 to C. Dr Ho summarised what had happened so far. He said that he had decided that there was a case to answer in respect of charge 8. He referred to Dr Haigh's concerns about C's comments. Dr Ho said that it was clear from the evidence that Dr Ali did not recognise that DM had had a perforation on 19 January 2017. It followed that Dr Ali could not have told C that on that day. Dr Ho considered that the matters should be dealt with at a disciplinary hearing. They were serious issues of conduct. If proven, C's actions could potentially amount to gross misconduct. Dismissal could be the outcome. The issues went to the heart of trust and confidence which an employer must have in its senior clinicians when they gave an account of issues arising from a clinical incident.

91. C's response was to produce documents about DM's imaging records. Dr Ho referred these to Mr Ireland and asked Mr Ireland to produce a second addendum report, in terms

of reference dated 27 February 2019. Dr Ho said that it was not clear how, or when, C had got these documents. Dr Ho said that this was new information which Mr Ireland had not previously seen. I say more about this in paragraph 136, below. C's belief was that he was the only person who could have looked at DM's scans at 16.32 on 19 January. That evidence clearly showed that he did look at DM's scans on that day. If the evidence did show that, it confirmed that he must have spoken to Dr Ali about DM on 19 January and that Dr Ali told him that DM had had a perforation and not a dissection. All the other cardiologists who had looked at the scans considered that the perforation was clearly visible. Dr Ho asked Mr Ireland to review the documents and any other material (including further interviews with witnesses) and to say whether there was a case to answer and, if so, why. The documents included a procedure report which showed that C had conducted a procedure on a patient between 17.18 and 17.54 on 19 January, a log that showed that DM's notes had been viewed from WX9795, and an email that said that WX9795 was in C's office.

92. Mr Ireland met C and exchanged emails with him. There was a formal interview on 21 March, attended by C's counsel. C was asked to describe what he remembered. C said that he had already done this. C read out a statement from his interview with Mr Ireland in April 2018. Other statements of C's were referred to and there were questions and discussion. C was sent a draft note of the interview to amend and approve.

93. In an email dated 22 March 2019, in response to the question whether C had seen a jet of contrast when he saw DM's scans, he replied that he had.

(e) Mr Ireland's second addendum report

94. Mr Ireland produced his second addendum report on 5 April 2019. In the second section of that report Mr Ireland described the questions he had considered that he should investigate, and then looked at the evidence in relation to them, including C's evidence. It seemed from the evidence given at the hearings in Dr Ali's case that Dr Ali did not know, at the time he met C on 19 January (16.30) that there had been two perforations. The events which followed their conversation seemed to be at variance with C's account. C said he saw the jet of contrast; Dr Ali that he did not. Had Dr Ali seen it, he would have realised that he had missed it previously, and would have had an echo done urgently. C says that he told Dr Ali to do an echo urgently. But C did not follow this up, despite knowing that there was a perforation which was not sealed and which could be life-threatening. It was impossible to know what Dr Ali and C said to each other. From his review of the evidence, Mr Ireland considered it 'highly improbable' that Dr Ali walked into C's office and told him that he had dealt with two perforations that day. 'In addition, [C] states that this took place prior to any images being viewed'. Mr Ireland did not believe that the evidence he had reviewed conflicted with the conclusions he had reached in his earlier report.

95. Mr Ireland concluded that it was likely that C's office was kept locked when he was not in it, and that it was likely that in January 2017, his computer was not used by others. He concluded that '911' was a generic user name and was used by others apart from C. It is likely that he used it around 16.30 on 19 January. There were 25 moving images and one still. It was not possible to tell from the log which images had been viewed. If the images were viewed, it was not possible to miss the perforation. The evidence showed that the images were viewed around 16.30 from the computer in C's office. There was no evidence that Dr Ali had gone into C's office, but Mr Ireland considered

that to be likely. There was no record of the conversation between them. It was clear from the disciplinary proceedings in Dr Ali's case that Dr Ali had treated DM as a dissection and not as a perforation. Mr Ireland summarised the evidence (which he had already considered) which had been taken into account by the Panel in Dr Ali's case. He considered it 'highly probable' that Dr Ali treated DM as a dissection and not as a perforation. The panels after the disciplinary and appeal hearings in Dr Ali's case had formed the same view. He, and the appeal panel, in its decision, had commented on the exchange of text messages. The appeal panel considered that the exchange was far from clear.

96. Mr Ireland considered that the evidence did not show which images were viewed. C has said more than once that Dr Ali told him there had been two perforations before the images were viewed. It was possible that C's memory was incorrect. The events after the conversation seemed to be at variance with the account given by C. C said he had seen the jet of contrast; Dr Ali said he had not. If Dr Ali had seen the jet during the conversation, he would have realised he had missed it before, and that an echo needed to be done urgently. C said he had told Dr Ali to do one urgently. But C did not follow this up, despite knowing that a perforation which was not sealed could be life-threatening. Dr Ali did not do an echo. Mr Ireland did not consider that the evidence he had reviewed caused him to revise his earlier conclusions.

(f) C's response

97. C responded in a document he sent to Dr Ho on 15 April 2019. He considered Mr Ireland's report to be a 'travesty of the truth'. He had 'gone out of his way to advance a case against [C] rather than looking, as he ought to have done, at matters objectively'. He described as 'the first factual inaccuracy and indeed deliberate misrepresentation' which set the tone of the report, the suggestion that the evidence considered by Mr Ireland was 'fresh evidence from [C]'. That was 'a flagrant and a serious masking of the truth in order to cover up serious failings on Dr Ho's part' to disclose the material in November. The material had been obtained under Dr Ho's instructions by Ms King and Dr Umerah. It was not provided by C. C had provided information which Dr Ho had had since November 2018. C would have expected Mr Ireland to investigate why evidence which was 'clearly relevant' had been deliberately withheld from him.

98. Mr Ireland seemed to be laying the ground for a completely new allegation, that C had looked up the scans but had not examined them, or had not examined them all. That had not been put in interview. It was farcical. Mr Ireland failed to say that C had given a consistent account throughout, no doubt because that would have supported C's case. It was nonsense to suggest that C would have looked at the images without Dr Ali. There was no reason why.

99. C was critical of Mr Ireland's reliance on the findings in Dr Ali's case. C was not asked to attend or give evidence. C criticised six aspects of the decisions at the disciplinary hearing and appeal.

100. Standard balloon inflation times are 5-15 seconds. Any inflation for longer than a minute is described as balloon tamponade, and is the standard treatment for a perforation. Balloon inflation if there is a dissection potentially makes it worse. The two-minute inflation suggested that Dr Ali had recognised that there was a perforation. Whether the inflation should have lasted longer was another question.

101. The witness statements from the nursing staff were unreliable. They had been collected nearly a year later. Staff were not properly interviewed. Their accounts conflicted with one another. One nurse said she had seen 'extravasation of dye', in keeping with a perforation, not a dissection. C was told that the image archive might have been corrupted and that the last image (of the dye leaking) was not the last image seen by staff at the end of the procedure. The statement that two nurses were oblivious of the emergency misrepresented the issue, as DM was 'deceptively completely well and stable'. She was walking around after discharge from the cathlab and the nurses were struggling to convince her to stay in bed. SC, by contrast, became very unwell in the cathlab. The emergency arrest team had to be called. DM and SC were treated differently for a simple obvious reason: SC was unwell and DM was not. All the cardiologists agreed that anyone who had reviewed DM's images would have decided that she had had a perforation, without a doubt. It was astounding and illogical that Dr Ali had not seen the perforation.

102. Some of Mr Ireland's points were irrelevant to the investigation he had to do, which was to see whether C's account was supported by the footprint evidence. Mr Ireland's effective finding that C had lied deliberately missed important questions, such as what C's motive might possibly be. Why, if it was not true, would C have said, when interviewed in February 2018, that he had accessed the scans, when he did not know that that could be checked. Mr Ireland failed to acknowledge that Dr Ali had been inconsistent throughout. C gave examples. Mr Ireland did not explain, given Dr Ali's inconsistencies, why C's account (that Dr Ali told him about two perforations) should be disbelieved. C, by contrast, had been consistent throughout. Mr Ireland had ignored the footprint evidence. Mr Ireland's investigation had found nothing other than facts to corroborate his account. He had ignored all the evidence and seemed to think that nothing short of an audio-visual recording would do.

103. Mr Ireland should have acted independently. Mr Ireland was not involved in the investigation of Dr Ali. Nor was C. It was 'nonsensical' to base his views on decisions made without C's involvement. C agreed with Martin Spencer J that those actions 'def[ied] belief'. C was not surprised by Mr Ireland's conclusion. He had acted repeatedly in 'a biased and partial way. The fact [that] he is willing to ignore powerful evidence raises serious concerns on his ability to conduct… an independent investigation'.

(g) Dr Ho's decision of 31 May 2019

104. On 31 May 2019, Dr Ho wrote to C. Taking into consideration Dr Haigh's two letters, Dr Ho had decided that there a case to answer. This was a fresh decision, not a review of his earlier decision. Dr Ho described some of the background. He referred to the footprint evidence. He 'very much appreciate[d] that [C] was unhappy that these separate inquiries were made and then not taken further'. Having considered Mr Ireland's second report and having discussed it with HR and with the Defendant's legal team, he did consider that the IT systems might be an unexplored avenue of potential evidence (see also paragraph 6 of Dr Ho's third witness statement). He considered that there might be relevant evidence, which could potentially be exculpatory, if the IT systems showed who accessed the relevant records and when. That was done to make sure he had the full picture before he made his decision. He had interpreted what he was told as confirmation that it was not possible to interrogate the systems to the level of detail needed to provide further help. He therefore decided not to take it further.

105. On reflection, and now seeing the full picture after C's disclosure of emails in January 2019 and Mr Ireland's third report in April 2019, Dr Ho accepted that the further inquiries led to further information being available. He apologised for the fact that the IT material had not been looked into sooner. On reflection, it might have been better to have asked Mr Ireland to look at these at the same time. He was mindful of the length of time the investigation had taken, and that Mr Ireland did not work for the Defendant and was not clinically qualified. He was concerned that further inquiries might delay things for no practical purpose. He was pleased that the IT material had been examined in detail so that they had the full picture.

106. He had considered Dr Haigh's views. Dr Ho agreed with most of Dr Haigh's views, but Dr Ho considered that part of Dr Haigh's letter 'speculates about what may or may not have taken place in terms of Dr [Ali] potentially having "set up" which images to show you'. Dr Ho respected Dr Haigh's assessment but he did not consider that such speculation was relevant to his own decision. He set those matters aside in reaching his own view. Dr Ho still considered that parts of Mr Ireland's reports (which he quoted) were relevant.

107. He noted that C asserted that the IT information clearly showed that C and Dr Ali must have discussed DM and that she had a perforation. Neither Mr Ireland in his reports nor Dr Haigh had that view. Accessing the electronic record may not show that a perforation was seen or appreciated. Dr Ho agreed with them that the evidence was not conclusive in the way that C suggested. The evidence suggested that Dr Ali could not have known on 19 January 2017 that DM had a perforation. Dr Ho summarised that evidence. Dr Ho was conscious that his role was not to decide whether or not the allegation was true, but to consider whether, on the face of the evidence, there was a case to answer at a disciplinary hearing. He was satisfied that there was, knowing full well that a disciplinary panel might, having heard the evidence, decide not to uphold the allegation. He was also satisfied that these were potentially serious issues of conduct. He still considered that C's actions could amount to gross misconduct if the allegation was upheld. The issues went to the heart of the relationship of trust and confidence.

Procedural irregularities

(1) the November 2018 investigation

108. In early November 2018, several messages and emails were sent about various records. Ms King was involved in these exchanges. She is D's HR Director. Her role in the disciplinary procedure is to act as secretary to the disciplinary panel, but not as a decision maker. On 5 November, she sent an email to 'Both'. The Defendant's solicitors had asked whether it was possible to tell who had accessed DM's scans on 19 and 20 January 2017. Dr Umerah then messaged Michael Phillips to say he had a question about scan records. On 6 November Ms Loudon-Bruce made an inquiry of Mr Bilal and Ms O'Hara about barrier access records about C, on behalf of Ms King. It was said to be urgent. She forwarded the outcome to Ms King on 7 November.

109. On 7 November 2018, Ms King asked Dr Umerah to liaise with Mr Phillips and find out who accessed DM's records on 19 and 20 January. It was 'very important and we need this urgently'. It should be kept confidential. She also needed to know if C had a patient in the cathlab in the afternoon of 19 January. She believed that C said he had come back at about 4pm for a patient. She asked him to check that. She said that 'Tim'

(ie Dr Ho) 'needs it urgently'. Dr Umerah replied at 4.28pm. He said that C was in 'in the pm of 19th January'. He sent an attachment showing that. DM's records had been accessed on 19 and 20 January, mostly from workstations in the cathlab. Two other computers had been used (WX12247 and WX9795), and IT was being chased to see where they were and who could have had access to them. Ms King emailed Dr Umerah and Dr Ho, thanking Dr Umerah for sending her the document, which showed that C was in for part of 19 January. Later that day, at 17.22, Mr Phillips emailed Dr Umerah. He had identified the two computers in the report. The first was at the angiography reception desk. WX9795 was in C's office. C points out that the information showed that DM's images were looked at from WX9795 at 16.32 on 19 January 2017 and that C started an operation on a private patient at 17.18.

110. Further emails sent on 7 and 8 November show that Claire Steel, the Head of Medical Director Services, who works both for Dr Umerah and for Dr Ho, was trying to find out where the two computers were and who had logged on to the two computers at the times listed in her email of 17.17 on 7 November. The upshot of her exchanges was that the local logs on the two computers did not go back far enough and that it was not possible to recover the information about log-on activity from the servers. On 8 November Dr Umerah emailed Ms King and Dr Ho. He said that IT had checked and there was no way of finding out who had used the computers. He described where both computers were.

111. D did not disclose this material to C at the time, although Mr Phillips did. As I have explained above, D did not take this material into account until much later, after C revealed that he had the material, in response to Dr Ho's decision of 25 January 2019. Mr Ireland was then asked to, and did, produce his second addendum report.

(2) the involvement of Dr Haigh

112. On 8 November 2018, NHS Resolution wrote to Dr Ho. The letter covered several topics. NHS Resolution suggested that, in the light of Dr Ho's concerns about comments made by Martin Spencer J, Dr Ho might want to consider recusing himself from the disciplinary process. It was a matter for him to discuss with the Defendant's legal advisers, and with his own.

113. On 23 November 2018, Dr Ho told C that following the advice of NCAS (that is, of NHS Resolution) he had decided to get an independent review of the case. C objected to this as it was against MHPS. On 30 November 2018 Dr Ho wrote to Dr Haigh, the Medical Director of Brighton and Sussex University Hospitals NHS Trust, and asked him to conduct an independent review of the case, to inform Dr Ho's decision whether or not the evidence suggested that there should be a disciplinary hearing. Dr Ho sent Dr Haigh the relevant documents. Dr Ho explained in cross-examination that he chose Dr Haigh because he was the Medical Director of a large respected Trust. He followed advice from NCAS.

114. Dr Ho told C that he intended to seek an independent view from a medical director at another trust. C objected by email. He said that it was against the MHPS. Dr Ho's response was that he had carefully considered C's comments. He had taken the advice of NCAS, and considered that this step was appropriate, even if a consequence was that the investigation would take longer.

115. Dr Ho sent a letter of instruction to Dr Haigh dated 30 November 2018. The letter was very short. It had 11 enclosures, including all the appendices to Mr Ireland's investigation report and first addendum report. Dr Ho asked Dr Haigh to consider whether there was a case to answer such that a disciplinary hearing was appropriate; if a hearing was not appropriate, what further steps, if any, Dr Haigh would recommend; and if a disciplinary hearing was appropriate, whether Dr Haigh considered the allegations serious enough that, if proven, they might amount to gross misconduct.

116. As I have already said (see paragraph 85, above) Dr Haigh gave his views in a letter dated 17 January 2019. His conclusion was that a disciplinary hearing was appropriate. He thought it unlikely, on balance of probability, that during the conversation or conversations between Dr Ali and C sometime after 17.00 on 19 January 2017, they discussed two cases of coronary perforation. He listed the eight factors he had taken into account in reaching that view. He considered that C had a case to answer because there was a possible conflict between C's statements that two cases of perforation were discussed on 19 January and the statement later made by Dr Ali, in which previously incorrect information provided to the Defendant and the coroner was corrected. Dr Haigh did not believe that a practitioner would submit a diagnosis of dissection to a coronial inquest unless he thought the diagnosis was correct. If the disciplinary process concluded that C provided misleading information about his discussion with Dr Ali, that could be gross misconduct.

117. Dr Haigh suggested, finally, that if this had not already been done, there might be value in interrogating the imaging system cross-referenced against the patient ID, the date and the time (post 16.00 hours). This might show under which staff log-in, and from which computer the images for DM were viewed on that day.

118. Dr Haigh was involved again when Dr Ho sent him a letter dated 18 April 2019. Dr Ho told him that he had decided that C had a case to answer and that after that, C had told him that he knew about some inquiries that had been made about IT systems information, which had not been included in Mr Ireland's report or disclosed to C. Dr Ho enclosed that material. He said that the context was that when he received Mr Ireland's investigation report, Dr Ho shared Dr Haigh's concern that there might be relevant evidence in the Defendant's IT systems. They might show who had accessed DM's records and C's movements on 19 January. He was also concerned that asking that question might extend the investigation when the IT system might have no relevant evidence. C might dispute Dr Ho's motives, but he decided to ask questions in principle about what information the IT systems held. Had Dr Ho believed from the response that there was relevant evidence, he would have asked Mr Ireland to investigate further. But he did not believe that the information he received took things any further. C disputed this.

119. When Dr Ho received C's representations, he commissioned Mr Ireland to report further. C applied, unsuccessfully, for an injunction to prevent that further investigation. Dr Ho asked Dr Haigh to review Mr Ireland's further report and the case more generally and to express a view about whether there was a case to answer. He was asking for Dr Haigh's views to inform his decision and 'to provide [C] with an additional layer of assurance as to a fair process'. He enclosed C's comments.

120. On 28 May 2019, Dr Haigh wrote to Dr Ho. Dr Haigh still considered it unlikely, on balance of probability, that during the conversation which took place on 19 January

2017, Dr Ali discussed with C two cases of coronary perforation. His reasons included some of the reasons he had given before. He summarised them in eight numbered paragraphs. The most controversial point, attacked by Mr Cavanagh as ridiculous, is that Dr Haigh considered whether Dr Ali accessed DM's images on C's computer in order to control which images were viewed later. If that had happened, the evidence of the perforation might not have been seen by C. Dr Haigh's conclusion was that on balance of probability, only one case of coronary perforation was diagnosed by Dr Ali that day, and discussed by Dr Ali and C.

(3) Delay

121. There is no doubt that there has been significant delay in the course of the disciplinary process. I consider its significance below.

(4) Bad faith

122. C has made allegations of bad faith against Dr Ho, Ms King, Dr Umerah, and has also criticised the motives and conduct of Mr Ireland. I consider whether those allegations are justified below.

Discussion

(1) Charge 8a

123. There are eight points.

a. Dr Gunning describes two moments at which Dr Ali should have taken action and did not; the point when the type II perforation became visible (when he says that Dr Ali should have stopped the procedure) and the point at which the perforation became worse (when he says that Dr Ali should have tried to manage the leak; there is no evidence either that Dr Ali recognised the perforation, or did anything to treat it). Although C described the procedure in his report of 1 July 2017 (presumably from the images) he did not identify the first point at which Dr Ali should have seen the type II perforation. He did not comment on this issue at all in his report.

b. C's position in his statement of 25 April 2018 is that the differences between him and Dr Gunning are, in effect, honest differences of professional judgment. He does not explain this assertion further.

c. C does comment on what in my judgment are significant points in Dr Gunning's analysis.

    i. The equipment chosen by Dr Ali was just too big for the artery; in particular, the 4mm stent was bigger than the artery (and, it followed, so was the 4.5mm balloon, when there was already a perforation).

    ii. There were other, better techniques for shifting the calcification.

    iii. The pressure used by Dr Ali was too great.

d. C did not before making his report look at any contemporaneous notes (see paragraph 15 of his report), although he did look at the images at some point, even though by then Dr Ali had, on 22 June 2017, shown him the procedure

report, in which Dr Ali did not describe a perforation at any stage, but a dissection. The fact that the account of the procedure in C's report is not, therefore, informed by consideration of the contemporaneous records, and the lack of any comment on the contemporaneous records, is an odd omission from that account. It makes that account, which is presumably just based on the images, significantly incomplete, in particular because the contemporaneous records suggest that Dr Ali did not recognise at any time during the procedure first, that there was a type II, and somewhat later, that there was a type III perforation, a suggestion reinforced by the fact that there is no evidence that Dr Ali took the steps he should have taken to treat and to monitor a perforation. C accepted in cross-examination that he did not know that Dr Ali had in his notes referred to the complication as a dissection. He accepted also that there were four references to a dissection in the contemporaneous notes. He was asked whether, against the background of the notes, for Dr Ali to have told him that there were two perforations was 'a very odd scenario'. His reply was that he could only say what he was told. He could see that anyone looking at the facts would find it improbable that a clinician who had described a complication as a dissection in his contemporaneous notes would then walk through C's door and describe the complication as a perforation.

e. C does not address the gulf between his one criticism of Dr Ali 'arguably and with hindsight the use of the 4.5mm balloon could have been avoided' and Dr Gunning's several trenchant criticisms of Dr Ali: 'significant error', 'cardinal error', 'foolhardy at best…catastrophic'. The impressions created by the report, therefore, are, first, that it is frank, in that it does make a mild and measured criticism of one part of the procedure, but, second, that there is not much to see here. This contrasts markedly with Dr Gunning's more detailed analysis, and criticisms, of different aspects of the procedure.

f. While it is true that C does not specifically endorse the account Dr Ali gave him of the steps Dr Ali took to stop the leak (prolonged balloon inflation), and while C does note that there is no image to show that the leak was sealed, importantly, C does not make clear that there are no images which support Dr Ali's account that he did use prolonged balloon inflation to seal the leak.

g. C suggested that 'up to that point' (which must be 22 June 2017) he did not know that Dr Ali had referred to the complication as a dissection in the cathlab report. He added that *at no point* had he or his colleagues felt that Dr Ali was trying to 'hide, mask, or cover up the complication he had encountered'. However he knew by 1 July 2017 that Dr Ali had recorded in his report for the coroner that the complication was a dissection and that Drs Umerah and Jewsbury were not happy with Dr Ali's stance.

h. A person who has read the material is left not understanding why, if both C and Dr Ali identified a type III perforation during their discussion, and given that the images did not show that it had been sealed, an immediate echo was not both ordered, and checked, and a regime of fastidious observation set up.

124. In all the circumstances, I consider that if I apply a rationality test, Dr Ho was entitled, rationally, to consider that there is a case to answer on charge 8a, and, that, if I have to decide for myself whether the evidence, at its highest, discloses a case to answer on charge 8a, it does disclose a case to answer. I appreciate that in this respect I am

differing from the view expressed by Martin Spencer J in his ex tempore judgment on the first application for interim relief. I have, however, reserved judgment, and have had the time to consider the documents in some depth, and to reflect on them. Mr Cavanagh understandably relied heavily on the views of Martin Spencer J, but he did not suggest that I am bound by them. I consider that his view that charge 8a does not disclose potential gross misconduct, or even misconduct, is clearly wrong. It follows that I reject Mr Cavanagh's submission that the criticisms in charge 8a are 'nit-picking' and that they amount to exposing C to the disciplinary procedure for a mere difference of professional opinion. It is not for me to express a concluded view, but I do consider that, taken at its highest, the evidence does suggest, not just a difference of medical opinion, but a significant and troubling understatement by C of the shortcomings in Dr Ali's treatment of DM. My view is not changed by the fact that at a stage when charge 8a stood on its own, D's view was that it did not amount to gross misconduct.

(2) Charge 8b

125. Charge 8b was prompted by the conclusions of the Panel in Dr Ali's case. I have summarised the way in which D investigated charge 8b in some detail.

126. C argues that there is no dispute that C had said, in March 2018, before the computer footprint evidence was seen by anyone, that on 19 January 2017 Dr Ali told him that he had treated two perforations that day and that he, C, had looked at DM's scans with Dr Ali. Mr Ireland found that C had looked at the scans with Dr Ali, corroborating C's account. Any cardiologist looking at the scans would have seen the perforation. It is 'ridiculous' to suggest that C, a very experienced cardiologist, who was clinical lead at the Hospital, looked up the scans with Dr Ali, and either did not look at them properly or did not look at the image which showed the perforation, and then lied repeatedly about it. This account is said to be supported by the text exchange with Dr Rex, which is said to show that the patient with a perforation whom C referred to was DM. It is also said to be supported by Dr Ali's accounts of DM's case at the MDT.

127. C argues that Mr Ireland's first addendum report is 'one-sided' and has seven mistakes in it. It is said, for example, that Mr Ireland 'completely overlooks' that Dr Rex said in an email that he was referring to DM in the text exchange. I consider, however, that Dr Rex's evidence about what he meant in the text message is irrelevant. Dr Rex did not communicate that to C; the question is to which patient C was intending to refer. That is a question which is to be decided by construing C's text message in its context.

128. C also criticises the second addendum report. It is said to lack objectivity. It mostly relies on the Panel's findings. C was not asked to attend the disciplinary hearing, or the appeal. C's response makes detailed criticisms of this Report. None has been addressed by Mr Ireland or by Dr Ho. C had no motive for lying. His account had been consistent throughout, whereas Dr Ali's had not. C does not understand why, given the consistency of his account, he should be disbelieved when he says that Dr Ali told him about two perforations. It is said that Mr Ireland and Dr Ho rely instead on Dr Ali's inconsistencies. Dr Ali is unreliable.

129. I have considered Mr Ireland's reports and Dr Ho's decisions carefully. In my judgment, Dr Ho was reasonably entitled to decide that there was a case to answer, and I conclude that, taken at its highest, the findings of Mr Ireland and the evidence do disclose a case to answer. Mr Ireland did not simply base his views on the bald

conclusions of the Panel in Dr Ali's case. Instead, he explored, in some detail, why the Panel had reached the conclusion it reached. The essential point is that a detailed review of Dr Ali's behaviour during and after the procedure on DM shows, in many different ways, that he could not have detected a perforation (as the Panel found). Rather, his behaviour was the behaviour of a doctor who had noticed a dissection. If he had not detected a perforation, it was improbable that he could have told C that he had, and especially improbable that he would have done so at the start of their encounter, before looking at the scans with C. Moreover, his behaviour after his meeting with C, and after looking at the images, was not the behaviour of a doctor who had detected a perforation on those images (assuming that he had not done so before). This behaviour made it improbable that he and C had detected a perforation by looking at the images together. The perforation was not visible on all the images, and it was not possible to tell from the footprint evidence which images were viewed. This, in turn, suggests that C's account might be improbable; indeed, Mr Ireland considered it 'highly improbable' that Dr Ali that Dr Ali had walked into C's office and told him that he had dealt with two perforations that day.

130. Mr Ireland considered in detail what the text messages between C and Dr Rex did or did not show. He was entitled reasonably to conclude that the text messages did not show that C knew that DM had a perforation. I also consider that the text messages are ambiguous and do not necessarily support C's account. By the time Dr Rex sent the text message, he knew that DM had had a perforation. There was no reason for him to 'correct' C's understanding, or to suspect that he and C might not be describing the same patient; but none of that is relevant to the material question, which is whether the text messages show that C knew that DM had had a perforation. One possible interpretation of the messages was that C only knew that one of the two patients had had a perforation. Mr Ireland noted that, in answer to a specific question, C had said that he had seen a jet of contrast when he looked at the images with Dr Ali; whereas Dr Ali had said that he had not seen one. Had a jet of contrast been seen, Dr Ali would have acted differently from the way he had; he would have ordered an echo immediately. He did not. The evidence did not show which images were looked at.

131. Mr Ireland considered the footprint evidence carefully. He was entitled reasonably to decide, for the reasons which he gave, that it did not provide any clear answers, and did not indicate that there was no case to answer. I do not consider that the footprint evidence is decisive, either.

132. These conclusions are not undermined by the criticisms which C makes of Mr Ireland's reasoning. For example, the fact that, when, in March 2018, C said that he had viewed the scans with Dr Ali, he did not know that there was a log in which there was limited information about when the scans were viewed is a neutral fact. It does not ineluctably show that C's account is accurate. The fact that a person who looked at all the images could not have failed to see the perforation is also a neutral fact, as there is no evidence which shows that all the images were viewed on 19 January 2017. It is not 'ridiculous' to suggest that C might not have looked at all the images, as whether he did or not may well depend on why he and Dr Ali looked at them in the first place. The fact that Dr Ali presented the case as a perforation seven days later at the MDT, and subsequently, does not show that there is no case to answer. The real issue on this point is how he behaved during and immediately after the procedure, which was the issue on which Mr Ireland concentrated.

133. Dr Ho accepted in cross-examination that what prompted charge 8b was the decision of the Panel in Dr Ali's case. He qualified that by saying that it was not just the Panel's conclusion, but the surrounding evidence which was significant. Dr Ho continued that he had asked Mr Ireland to look at all the evidence afresh, and he had reviewed it. The outcome in Dr Ali's case was not the only consideration. I accept his evidence.

(3) Serious and irremediable procedural errors

134. I have not in this section of the judgment considered every criticism of D's procedure. I have, instead, concentrated on those criticisms which seemed to me to be the most potentially serious criticisms, and thus the most likely candidates to satisfy the criterion of seriousness which is articulated in *Chhabra*.

(a) The November 2018 investigation

135. D (in particular Ms King, Dr Umerah, and Dr Ho) made an error of judgment in investigating the footprint and associated evidence about events on 19 January 2017 outside the framework of the MHPS, and, having investigated, in not telling C what they had discovered. They had many opportunities to disclose this information to C or to his solicitors, but did not do so. Dr Ho was reasonably entitled, and right, to conclude that the evidence was not decisive, but wrong, as he now accepts, to decide that it was not relevant, and that C did not need to be told about it. Dr Ho was also partly wrong in his letter of 27 February 2019 to describe this material as 'fresh evidence' from C. D had had it since November 2018, and D had instigated the investigation which produced it. The log-in evidence, however, was new to Dr Ho (I accept his evidence in cross-examination about that). MHPS does not permit the case manager to instigate, or be involved in, an investigation in this way.

136. Such conduct was likely to, and did, cause C to doubt that the approach of D and Dr Ho to the disciplinary process was scrupulously fair, as Dr Ho accepted in cross-examination. Dr Ho accepted that this was an error of judgment. There is no evidence that Dr Ho acted in bad faith in this respect. It was not suggested to him in cross-examination that he had. The position might have been different if, as C asserts, the footprint evidence had exonerated him. But in my judgment it does not do so. Mr Ireland found on the basis of this material that it was likely that C had viewed DM's images in his office with Dr Ali at about 16.32 on 19 January 2019. So this material partly corroborates C's account. It does not, however, show which images C and Dr Ali viewed, which is the crucial question. This irregularity is nothing like as serious as the involvement of Mr Wishart, contrary to an express undertaking, in Dr Chhabra's case. For these reasons I do not consider that this error was a procedural irregularity of such seriousness as to justify the grant of an injunction, either on its own, or taken cumulatively with the other irregularities on which C relies.

(b) The involvement of Dr Haigh

137. There is no provision in the MHPS for an independent third party to express a view on whether there is a case to answer. Dr Ho was understandably concerned about criticisms made by Martin Spencer J in his judgment on C's application for an interim injunction. In particular, Martin Spencer J held, at paragraph 87 of his ex tempore judgment, that

Dr Ho's position was irrational (in the public law sense). Dr Ho took appropriate advice. He concluded that it would be sensible to ask an independent doctor for advice. As he put it in cross-examination, when asked whether he should have recused himself, he felt he could carry out his role, but with a safeguard, which was to seek advice from an external medical director. I do not consider that there was anything devious or unfair about this. MHPS makes no provision for such a process. I accept Dr Ho's evidence about why he involved Dr Haigh. It was not suggested to him in cross-examination that he acted in bad faith, and having seen and heard him cross-examined, I have no hesitation in finding that he did not. Dr Ho decided to involve Dr Haigh as procedural safeguard. This procedural irregularity was very minor. It was not serious enough to justify the grant of an injunction, either on its own, or taken cumulatively with the other irregularities on which C relies.

(c) Delay

138. There has been a good deal of delay in this case. Some of the delay may have been caused by this litigation. Some of it was caused by the need to involve Mr Gunning, an independent outside expert, and by Dr Ho's decision to involve Dr Haigh, an independent Medical Director, both of whom had other professional commitments in the relevant periods. Further delay was caused by the need to ask Mr Ireland to produce a report on the footprint evidence, the need for which should have been clear in November 2018, and by Dr Ho's decision to ask Dr Haigh for his views on that evidence also. Some of the delay is due to the necessary formality of the procedure. The addition of charge 8b, after Dr Ali's hearing and appeal, caused further delay. Apart from the delay caused by the footprint evidence, the delay, while regrettable, is not, in my judgment, culpable. I appreciate that the delay will have caused and will continue to cause C great anxiety. I do not, however, consider that the delay is such as to prevent a fair disciplinary hearing. Nor do I consider that it is a procedural irregularity which is serious enough to justify the grant of an injunction, either on its own, or taken cumulatively with the other irregularities on which C relies.

(d) Bad faith

139. In his witness statements, C made many allegations of bad faith.

a. He made such an allegation in paragraph 26 of his third witness statement against Dr Ho.

b. In paragraph 42 of that statement, he made a further allegation of bad faith against Dr Ho and Ms King.

c. In paragraph 44 of the same statement, he accused Dr Ho, Ms King and Dr Umerah of wrongdoing.

d. In paragraph 5 of his fourth witness statement, he accused Dr Ho, Ms King and Dr Umerah of bad faith. He suggested that they were sitting on evidence which exonerated him in the hope that it would never come to light. He says the evidence exonerated him.

e. In paragraph 15 of the same statement, he said that Dr Ho had 'potentially' lied.

In paragraph 134 of their skeleton argument, his counsel accused those involved in the November investigation of a 'deliberate cover-up'.

140. Only Dr Ho gave evidence at the hearing. He gave his evidence in a balanced way. He made concessions where they were appropriate. On many issues, it was clear that he had not formed a view, because he rightly declined to speculate. For example, he declined to speculate about C's motives. It was not directly suggested to him in cross-examination that he had acted in bad faith. It was suggested, rather, for example, that he was determined not to lose face, that he had lost all sense of proportion, and that he really did not like C. I do not consider that there is any evidence that Dr Ho acted in bad faith, and I find that he did not.

Conclusion

141. For these reasons, I find that there is a case to answer on charges 8a and 8b, and that Dr Ho was reasonably entitled to decide that there was. I do not find that any of the procedural irregularities relied on by C is, whether by itself, or cumulatively with others, serious enough to justify the grant of an injunction. I therefore dismiss this application.