

Neutral Citation Number: [2012] EWHC 857 (QB)

Claim No: 1LV90060

**IN THE HIGH COURT OF JUSTICE**  
**QUEEN'S BENCH DIVISION**  
**LIVERPOOL DISTRICT REGISTRY**

Liverpool District Registry  
35 Vernon Street, Mersey Side,  
Liverpool, L2 2BX

Date: 03/04/2012

**Before :**

**MR JUSTICE BLAIR**

**Between :**

**Dr. A**  
**- and -**  
**HTX**

**Claimant**

**Defendant**

**Mr Simon Gorton QC and Ms Nicola Hunt** (instructed by **Morecrofts LLP**) for the  
**Claimant**

**Mr Giles Powell and Ms Nicola Newbegin** (instructed by **Hill Dickinson LLP**) for the  
**Defendant**

Hearing dates: 12th, 13th, 14th, and 15th March 2012

**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.

.....

MR JUSTICE BLAIR

## **MR JUSTICE BLAIR:**

1. By these proceedings, the claimant, a consultant paediatrician with the defendant which is an NHS Trust (the “Trust”) seeks a final injunction restraining the Trust from referring her case to a panel considering issues arising from her ill health. An interim injunction was applied for at a hearing before His Honour Judge Wood QC on 18 November 2011, but in the event the defendant gave undertakings pending trial. The judge ordered a speedy trial. This is the substantive hearing. The injunction (or the making of a declaration that would have the same effect) is based on allegations that the defendant has acted in breach of contract by excluding the claimant from the hospital where she worked, and is in breach of the implied duty of trust and confidence that exists between employer and employee. Accordingly, the claimant submits, the defendant should be restrained from convening the panel hearing. There is no claim for damages (the claimant has remained on full pay throughout). For its part, the defendant Trust denies the allegations of breach of contract, and asserts that it is entitled to take the view that the panel should determine the issues as to the claimant’s continued employment that have arisen between the parties.
2. On what was effectively the joint application of the parties, Judge Wood QC also ordered that the names of the claimant, the defendant Trust and the medical staff concerned should be anonymous. In doing so, he applied the criteria set out by Lord Neuberger MR in *H v News Group Newspapers Ltd* [2011] 1 W.L.R. 1645 at [21]. Such an order must be regarded as exceptional, but applying the criteria set out in that case, and in view of the fact that this case concerns a paediatric department, and the mental health of one of its physicians, I consider that exceptionally the order was justified, and have applied it in the course of this judgment.
3. At trial, the claimant gave evidence, and called a witness, Dr Howard Waring, the psychiatrist presently treating her. Witness statements were also served from Captain Philip Higton, director of training at Terema Ltd, as regards ways of facilitating a consultant’s return to work, and Dr Barbara Phillips, a retired consultant paediatrician, who worked with the claimant at one time and speaks of her skills. Without accepting their evidence, the defendant did not actively challenge it, a practical stance which meant that neither of them had to be called.
4. The names of witnesses called by the defendant Trust are anonymised in accordance with the order of Judge Wood QC. The defendant called Dr K, a Consultant in intensive care medicine, who recently took over as case manager in relation to this matter. The original case manager (who did not give evidence at trial) is (or was) away on sickness absence. Its other witness called was Ms HRT, who is Director of Human Resources, having worked in that role since July 2003, and who is now Deputy Chief Executive for the Trust.
5. Both parties prepared chronologies, and as regards documents, there was a helpful core bundle which was supplemented by reference to the documents referred to at the hearing.
6. The four witnesses including the claimant herself who gave evidence at trial were cross-examined in an appropriate manner and length, given the nature of the case. I found that their oral evidence gave considerable perspective to the matters in dispute.

7. In setting out my findings of fact, I state at the outset that I am concerned only to find the facts necessary to determine the claimant's claim, which (as pleaded) is essentially a claim for a final injunction. I have not generally had to reach conclusions as to the rights and wrongs of individual incidents, of which a number are said to have happened. That is not the function of the court in these proceedings, except insofar as it is necessary to decide the issues, and in particular whether the defendant Trust should be restrained from convening the ill health panel, as the claimant asserts. The answer to that question depends primarily upon whether the defendant is in breach of the claimant's contract of employment in deciding to take this course, and if so, whether the court should grant an injunction preventing it. A principal area of inquiry therefore is as to the parties' respective cases as to the terms of the contract, and whether the defendant is acting or threatening to act in breach of them, and the consequences.

#### The facts

##### ***The claimant's early career before employment with the defendant***

8. The facts as I find them are as follows. The claimant, who is in her mid 40s, began her medical career in Nigeria. From 1990, she held various posts in paediatric medicine in a number of different hospitals in this country. She says, and I accept, that prior to the birth of her youngest child in November 1998, she did not encounter any problems in relation to her mental health.
9. She explains in her witness statement that after that birth, she was diagnosed with post-natal depression, and in March 1999, when very ill, was admitted to a specialist psychiatric hospital. Her recollection of the precise details of what happened is limited because of the state of her health at the time. The records show two episodes of attempted suicide at this time.
10. She was unwell again in early 2000. She says that a high dose of anti-depressant triggered a manic episode, which on 3 March 2000 led to her being detained under s.2 Mental Health Act 1983. On discharge the following month, the diagnosis of her condition was revised to bipolar disorder.
11. As explained by Dr Adrienne Reveley, who is one of a considerable number of psychiatrists whose reports are in the material before the court, this condition is also known as bipolar affective disorder, or manic depression. This is a recurrent psychiatric condition characterised by intermittent periods of depression in mood (which may include psychosis), as well as intermittent periods of manic or hyper manic mood and/or mixed mood states. In between episodes, the individual maybe entirely normal, but the risk of recurrence is high.
12. In the case of the claimant, I note that there has (from time to time) been an alternative diagnosis of severe post-natal depression (that is, unipolar disorder). However, the overwhelming consensus is now that the original 2000 diagnosis of bipolar disorder is the right one. I am satisfied from the evidence that the claimant has had considerable difficulties in accepting this diagnosis. The problem has been (as the psychiatrists describe it) a lack of insight. This reflects an aspect of the disorder, namely that the sufferer is unable to recognise that he or she is unwell, perhaps very seriously unwell, and it has been a significant element in the facts of this case.

13. According to the documents, the claimant was treated for a period between about 1999 and 2002 by Dr Claire Sillince, the Consultant Psychiatrist who had treated her on her section 2 admission to hospital.
14. The claimant recovered, and returned to work as a specialist registrar. There is some doubt about the sequence of her employment over the next few years. She worked for a short time in 2002 as a locum with the defendant Trust. In the relevant box of her pre-employment questionnaire, she only disclosed “depression after child birth”. She became unwell again in December 2002, and resigned due to ill health. In July 2003, the GMC imposed restrictions on her practice by way of supervision by a consultant psychiatrist.
15. According to her statement, she began employment at another trust (not the defendant) on 5 January 2004, working without supervision except for that imposed by the GMC, until she took up her present position on 3 January 2006. The same dates appear in her c.v., but she accepted in cross-examination that they were not accurate. She said she worked there between April to May 2005, and July 2005 to January 2006. In between, she worked at a different hospital.

***The claimant's employment with the defendant***

16. The defendant Trust provides a full range of services to an immediate local community with a population of about 350,000. Each year, the surgical team at the Trust undertakes 700 routine operations on children aged between 1 year and 18 years old. The paediatric provision at the trust is relatively small, including 25 inpatient beds plus a dedicated paediatric high dependency unit with two beds, and twelve short stay beds. There are presently about nine consultants within the Paediatric Directorate (including the claimant).
17. On 26 April 2005, the claimant was one of two candidates interviewed for a consultant paediatrician post with the Trust. The Trust had made routine inquiries with the GMC, and was aware of the restrictions on her practice. In the relevant box of her pre-employment questionnaire, she only disclosed “post-natal depression”. According to Ms HRT (the Director of Human Resources), who I consider was reliable as a witness, at interview she said only that she suffered from post-natal depression, and was subject to medical supervision as result of this.
18. This is now a matter of history, but I am satisfied that the Trust was not fully made aware of the claimant's health problems at this time. Because of the incomplete nature of her disclosure, she must take some of the responsibility in this regard, though enquiries by the Trust which were in fact made after the interview, could have been made before, and would have revealed the full position.
19. In any event, the claimant presented well at the interview, which was conducted by a panel of seven, including five doctors, the Trust's Chief Executive, and a non-executive director as chair. She was offered the position orally at the end of the interview, subject to satisfactory references and medical clearance.
20. After the interview, Ms HRT made inquiries as to who the claimant's supervisor was at the GMC. Inquiries were in due course made of the psychiatrist nominated by the

GMC, as well as her treating clinician. Both expressed the view that she suffered from bipolar manic depressive illness.

21. Dr N was (and is) the Clinical Director of the defendant's Paediatric Department. He has, as one would expect, played an important role in this matter. At about this time, he wrote to the GMC medical supervisor (a consultant psychiatrist called Dr RW Jones) asking whether it was appropriate for the claimant to undertake the proposed duties, and about the risks of general recurrence and also the risks of a sudden relapse, as well as the risk to the claimant as she would often be the senior person on call.
22. It may be noted that Dr N had been on the interviewing panel. His letter suggests that it was prompted by a realisation that in 2002 the claimant had been employed as a locum at the Trust but left her post suddenly because of ill health. Dr Jones responded to the effect that the claimant had been stable for at least 9 months and had discharged her A&E duties with good reports from her supervising colleagues.
23. Dr N also raised these concerns with the Trust's Chief Executive. In the course of the letter, Dr N referred to a conversation with Dr Jones, saying that he "...suggested local, i.e. departmental as well as Trust level monitoring of [the claimant's] mood so she could be referred to a psychiatrist at the slightest sign of mood change". Dr N went on to say that whilst no one doubted her competence, he would "...ask the Trust to consider the circumstances and implications of this appointment very carefully before committing to it". It was suggested on behalf of the claimant in the cross-examination of Ms HRT that this showed that the defendant was aware of the need to monitor the claimant for signs of mood change. I accept her evidence rejecting that suggestion because at the time this concern was (or appeared to have been) allayed.
24. This occurred over the next few months in the course of various exchanges involving the Trust's Occupational Health Physician, at that time Dr X. In October, he expressed the view that the claimant should be able to work in the post and that no other arrangements were necessary.
25. On 31 October 2005, she was released from her undertakings by the GMC. She was confirmed in the post by the defendant, and started work on 3 January 2006. She commenced employment without any supervision save during induction period.
26. When well, I am satisfied that the claimant is a competent doctor in the demanding field of paediatrics. There is no suggestion of any problems arising in 2006, and on the retirement of the psychiatrist who had been treating her, she stopped taking her medication. I do not accept the assertion on behalf of the claimant that what is "striking is that so much energy was dedicated by the defendant to ensuring that the claimant could do her job with her condition, whilst none appears to have been dedicated to the simplest task of keeping an eye on matters when she was employed". I accept Ms HRT's evidence that the claimant was believed by the defendant to be well.

### ***The 2008 investigation***

27. In 2007, a number of concerns about the claimant were raised by the lead paediatric nurse, including as regards communication with parents. On 29 January 2008, a joint letter was sent from the Trust's paediatric consultants to Dr Y (the Medical Director)

as regards a number of specific matters. The fact that this was a joint letter was clearly somewhat unusual. On 20 February 2008, she was told that an investigation would take place. Dr Y, who was the Medical Director until recently, has also featured extensively in the evidence.

28. The conclusion in a draft report by the Consultant Physician who had been appointed case investigator dated 29 May 2008 referred to the “overwhelming support” the claimant had from staff, and reached the conclusion that no further action should be taken. The draft report did however raise concerns regarding interpersonal relationships and behaviours which needed to be addressed.
29. The draft report made a number of recommendations. The claimant, it was said, needed to make sure that she was fully acquainted with all paediatric policies relevant to the Trust. The Trust should be prepared to support her with an understanding of how the NHS works. It needed to be prepared to support her, the report said, with her personal development, especially with regard to team working, interpersonal skills and a high standard of professionalism in relation to colleagues. This could be provided by counselling, behaviour therapy and close mentorship.
30. The claimant responded to the draft report by letter of 23 June 2008, saying that she was happy to engage with the recommendations. Unfortunately, the case investigator thereafter had a prolonged period of absence through illness. When he returned to work in about December 2008, Dr Y wrote to the claimant to the effect that no further action would be taken. He asked her to arrange a meeting with him to address matters raised in the report.
31. Some criticism is made on behalf of the claimant to the effect that the defendant did not follow up on the recommendations as to support set out in the report. On balance however it seems to me that the opportunity to take more concrete steps by way of support was overtaken by events in February and March of the following year, which I shall come to.
32. It is also said that the draft report should have alerted the Trust to the fact that the claimant’s health was deteriorating at this time. This point is not established in my view. The report expressly states that, “There are no health issues”. As a description of the claimant’s medical condition at this time, there was no reason for the Trust to go behind that assessment.
33. I should also note that the view of the consultant physician who had investigated the matter was that the problems that he had identified were not intractable. This assessment (at least as at that time) is consistent with other evidence, for example, an appraisal dated 10 October 2008 by which Dr N favourably rated the claimant's performance.

#### ***The events of early 2009 leading to the claimant’s exclusion***

34. Unfortunately, serious problems ensued relatively soon thereafter. As it is put in her closing submissions, the claimant dramatically declined through March. Apart from that of the claimant and Ms HRT (the Director of Human Resources), there was only a limited amount by way of witness evidence at trial from people directly involved. But

the nature of the matters being reported to the defendant Trust is relatively clear from the contemporary documents.

35. On 2 February 2009, the claimant's husband called to say that she was sick. At about that time, there are emails from the lead nurse and Dr N (who as I have said is Clinical Director of the Paediatric Department) expressing concerns including as to late notification of absence.
36. In fact, she returned to work on 23 February 2009, the medical certificate referring to "fatigue". She indicated to Dr N that she would like to reduce her hours to three days per week, and less on call. By letter of 7 March 2009, she asked to be exempt from all on-call commitments due to family circumstances. She was told that this would be considered, but again this was overtaken by events.
37. In outline, what happened over the next few weeks was as follows. There were complaints from her secretary that she was not dictating letters, or would dictate one and not others, and when asked to do the letters, would dictate the same letter again. The evidence is that the secretaries generally were increasingly concerned about the claimant's behaviour, which they said included shouting.
38. On 3 March 2009, the claimant gave a Grand Round presentation (these are cross-disciplinary presentations given by different doctors on a weekly basis during university term). One of those present was Dr K, a Consultant in Intensive Care Medicine. He as I have said recently took over as case manager in relation to this matter, and was one of the two witnesses who gave evidence for the defendant at trial. This was the only matter of which he had first hand knowledge. He said, and I accept, that the claimant sat beside him at lunch afterwards. Based on comments she made about her "colleagues killing people" and "people getting away with murder", he informally suggested to Dr Y later that "her behaviour suggested that she was psychotic".
39. Around this time, there is evidence from nurses about complaints received from the parents of patients. According to one, the claimant's manner came across as though she could not be bothered. She was described as being "dormant" when asked about the child's admission to hospital.
40. As regards students, the evidence from the Investigation Report subsequently carried out is that of twelve evaluation forms from undergraduates, seven raised concerns about the claimant's behaviour and conduct. This included her behaviour on ward rounds. (This contrasts with a letter to her of 3 February 2009 from Dr Y to the effect that in July 2008 the claimant was nominated as a clinician who had contributed to the learning experience of medical students.)
41. An incident took place on 6 March 2009 as regards the doctor with whom she shared an office, which resulted in that doctor asking to move into another office.
42. On 18-19 March 2009, an APLS (advanced paediatric life support) course took place at a neighbouring hospital. The claimant had agreed to instruct on the course. The course director was Dr R who was Consultant in Paediatric Emergency Medicine at this hospital. Dr R emailed the Trust shortly afterwards to the effect that during the course, the claimant's "... behaviour was inconsistent, and her manner often abrupt.

[The claimant] seemed paranoid, and I think probably psychotic. I am very concerned for her mental health, and the impact this may have on her clinical work". She decided that the claimant should not teach on APLS for the time being.

43. On 26 March 2009, the Named Midwife for Safeguarding Children encountered the claimant at the hospital. She described the claimant's behaviour as hostile, and inexplicable. The midwife noted that this was "totally out of character".
44. On 27 March 2009, Dr R (the course director at the APLS course) wrote to the claimant "I'm really sorry to do this..., but I must do what is right. I have discussed an outline of my concerns with the BMA and, because there may be an issue with patient safety, I am going to speak and write to [Dr N] as he is your line manager". This, she did.
45. On 27 March 2009, Dr L, another Consultant Paediatrician in the department emailed to the effect that there had been communication problems since the start of the claimant's job, despite "many efforts to try and work with her". However, it was asserted that there had been over the past 2 or 3 months an escalation and grave deterioration. Dr L referred to concerns about the claimant's welfare.
46. Taken slightly out of sequence, a detective constable from Merseyside Police wrote to the Trust on 31 March 2009 raising concerns about the claimant's communication skills, and requesting that future reports be dealt with by other consultants.
47. Matters came to a head on 30 March 2009. Dr Y (that is, the Medical Director at the Trust who handled this matter until ill health intervened at the end of 2011) attended unannounced at the end of the claimant's morning clinic, with Dr N and a representative of HR. According to the meeting note he prepared, he did this because she had shown reluctance to meet with him over several pre-arranged appointments. The urgency arose from the email that had been received from Dr R about the APLS course. He thought she had very little insight, and asked her to undertake a health assessment that had been arranged for 1 pm that day. He asked her to accept a period of exclusion from the Trust in order that it could undertake an assessment of her health and wellbeing.
48. The claimant did not attend the appointment on 30 March 2009, or subsequent appointments. The exclusion was confirmed by letter of 2 April 2009. She did however attend an appointment with Dr O, in the Trust's Occupational Health Department on 17 April 2009, and as a result, she was declared unfit for duty.
49. There is an undated letter from the claimant dealing with these matters as they were raised in the subsequent investigation. In that letter, she made it clear that she did not agree with many of the complaints which had been made about her behaviour.
50. However, in her witness statement and in her oral evidence, the claimant did not challenge the detailed account given on behalf of the defendant of the events of early 2009. In her witness statement she says simply that having reflected on the documents she has now seen, it is her view that during late 2007 and into 2008, she became unwell intermittently, "but the symptoms I was displaying were less severe than those that followed in early 2009, when I became seriously unwell".

### *The investigation*

51. There is a great deal of material following the claimant's exclusion. The parties only referred to a relatively small part of it at trial, which is reflected in the following findings.
52. Although a scheduled appointment with Dr O (at occupational health) was deferred by the claimant, she did attend on 17 and 21 April 2009. Dr O thought that she was unfit for duty.
53. The MPS (Medical Protection Society) was involved on behalf of the claimant by this time (and solicitors relatively soon afterwards). According to her chronology, by letter of 22 April 2009 the MPS requested copies of correspondence, and asked what alternatives to exclusion were considered. To jump ahead, on 20 May 2009, Dr Y responded to the effect that he could not identify a role where the claimant would not be put in a situation that exposed other members of staff to her behaviour.
54. On 27 April 2009, Dr Y wrote to her to confirm that he had commissioned an investigation under s.2.2 of the Trust's Policy on Handling Concerns about the Conduct, Performance and Health of Medical Staff. He was to be the case manager, and another doctor, a Consultant Radiologist called Dr V, was to be case investigator.
55. By letter of 29 April, NCAS was contacted for advice by Dr Y. By letter of 1 May 2009, NCAS wrote back, making a number of points, including that it would be necessary to await reports from the occupational health physician and specialist assessor. This was the first of a considerable number of such exchanges between the Trust and NCAS.
56. The GMC was also involved at this time. According to a letter of 13 May 2009 referred to in Dr K's witness statement, Dr Y told them that the claimant showed a lack of engagement in the ensuing process.
57. On 20 May 2009, Dr Y wrote to her stating that he had reviewed her exclusion in conjunction with the Director of Human Resources and Trust's Chief Executive, and that the exclusion would remain in place. This was the first of numerous reviews. The claimant contends that they were defective, because they were retrospective rather than prospective.
58. On 8 June 2009 following a hearing which the claimant attended with legal representation, the GMC's Interim Orders Panel imposed a number of conditions on the claimant's registration.
59. In June 2009, the case was referred by the defendant to Dr P Mbaya, a Consultant Psychiatrist at the Priory Hospital, Altrincham. On 15 July 2009 Dr Mbaya stated that the claimant had suffered from severe post natal depression, and that she was fit to undertake the role of consultant paediatrician. The claimant places reliance on that report, and her case is that she has been fit and well to return to her duties since at least late Summer 2009.
60. There is not (in my view) sufficient evidence to establish this, though it may be so. The reason I express that view is that there appears to be substance in the defendant's

assertion that Dr Mbaya was not provided with adequate material to express a proper opinion (a criticism which they appeared to make about the claimant's solicitors, though I have not seen any evidence of that). In any case, Dr Mbaya's diagnosis was inconsistent with earlier diagnoses, and in my view, the defendant was entitled to seek to explore the matter further.

61. According to an email of 4 August 2009, at an interview between occupational health and the claimant, the Trust asked to contact Dr Claire Sillince who (as I have explained) had treated her earlier, but the claimant said that it was years ago, and refused to give permission.
62. On 6 August 2009, the claimant had an interview with Dr V, the case investigator. According to the notes, she was very surprised there was a problem, and in his report Dr V said that he thought that she showed no insight as regards her behaviour prior to the exclusion, or why colleagues were concerned for her wellbeing and conduct.
63. On 13 August 2009 Dr O'Brien, a consultant psychiatrist, prepared a medical report for the GMC, diagnosing bipolar disorder currently in remission, and concluding that the claimant was not fit to practice except under medical supervision.
64. On 17 August 2009, a further GMC assessment by Dr Benjamin John, although diagnosing unipolar depressive disorder, reached the same general conclusion (although he refers to "light leash" supervision).
65. On 21 September 2009, Dr V completed his investigation report. He said that: "To conclude, the investigating officers share reasonable belief from the evidence provided that the behaviour that [the claimant] displayed prior to her exclusion was not appropriate for a professional employee of the NHS. Her inappropriate behaviour has led to an irretrievable breakdown of a working relationship between [the claimant] and the Trust. Unfortunately, she has no insight into this problem".
66. He made various recommendations including that there be an independent psychiatric assessment of the claimant's mental state, and her removal from the paediatric directorate: "the nature of the paediatric work could potentially be contributing to [the claimant's] condition and to ensure the safeguarding of patients".
67. On 2 October 2009 the claimant wrote to Dr Y requesting a phased return to work.
68. Following exchanges with NCAS, the position was again reviewed by Dr O (of Occupational Health). On 5 November 2009, Dr O provided a report to Dr Y to the effect that the claimant lacked insight into her condition, and that the opinion of Dr Mbaya could not be relied upon because he gave a different diagnosis. Dr O believed that her condition (bipolar disorder) was exacerbated by the stressful situations prevalent in the busy paediatric unit. He concluded that he did not think it would be possible for her to return to her normal duties, and that there were no adjustments that could be made to support a return to work at that time.
69. This led to a letter which (in substance) contains the position that the Trust has maintained since. On 25 November 2009, Dr Y wrote to the claimant to the effect that the matter was to be categorised as an ill health issue. He said that, "My view, having considered the evidence at this preliminary stage, is that there is a case to

argue that a return to work cannot be effected so as to ensure reasonable performance of your duties and that such adjustment cannot be necessarily made. I hasten to add that this is a preliminary view.”

70. Dr Y said in the letter of 25 November 2009 that a hearing would take place under the Trust’s ill health procedure by analogy with the disciplinary procedure in terms of relevant personnel and procedure. There would be an appropriate external consultant paediatrician to advise, and in attendance there would be an external HR adviser.
71. Dr Y said that he had reconsidered the claimant’s exclusion from work, but that there remained significant doubts as to her ability to perform her duties satisfactorily. He was “... hopeful that this matter could be addressed in a matter of a few weeks at the longest. I have consulted with NCAS as to my decision”.
72. At about the same time, the GMC removed the practice restrictions, the claimant giving appropriate undertakings instead.
73. On 8 December 2009, the claimant’s solicitors wrote to the Trust’s solicitors to the effect that no hearing should take place, and threatening an injunction. Again, it is to be noted that this essentially has remained the claimant’s position since then.

***An independent psychiatrist is jointly instructed***

74. By this time, it appears that dealings between the parties were primarily through their respective solicitors. The hope expressed by Dr Y that the matter would be resolved within a few weeks was not to be fulfilled.
75. On 18 January 2010, the Trust’s solicitors wrote to the claimant’s solicitors suggesting that a further report was produced by an independent psychiatrist. It may be that this was done to follow the recommendations of Dr V’s investigation, I do not know. It meant that the ill health panel could not be convened at that stage, and on 19 January 2010, Dr Y wrote to the claimant referring to the correspondence between the solicitors, and saying that in the light of the decision to instruct an independent psychiatrist, he would not arrange any hearing until the report had been received.
76. By letter of 12 February 2010, the claimant’s solicitors proposed that Dr Mbaya should provide a further report.
77. On 4 and 5 March 2010, there was an exchange of emails between Dr O and Dr Y upon which the claimant places reliance as showing that the proposal to refer to an independent psychiatrist was “insincere”.
78. Dr O said in his email that he felt that the psychiatrists as a group had failed to grasp the extent of the problem. As regards further reports, he thought that they were going to be “in the same boat with any other psychiatrist unless we can use Claire Sillince who is the only one who has mentioned the lack of insight”. His opinion was that the claimant was not fit to return to the post of a consultant paediatrician, and would remain unfit for the foreseeable future. He thought that the right course was to terminate her employment on grounds of ill health, though that would end in a Tribunal hearing: “however, no matter what happens this is better than a court case for the negligent death of a child”.

79. Dr Y responded to the effect that, “The addition[al] risk is that more and more psychiatric reports in support of the absence of mental health issues currently give further support to the views that she is fit to return. Our legacy of experience must be the basis on which we restate our concerns about her fitness to resume duties and our belief that no meaningful adjustments can be made”.
80. It is submitted on behalf of the claimant that this shows a “strategy to block the claimant’s return and facilitate her dismissal... plainly, the defendant had set it face against the claimant’s return...”.
81. It is correct (in my view) to say that this email exchange shows that the two doctors, who had first-hand experience of dealing with the episode of February/March 2009, did not consider that reasonable adjustments could be made at that time to enable the claimant to return to work. However, they do not in my view show a “strategy” to prevent this. As Medical Director, Dr Y had responsibility to ensure the proper and safe operation of the paediatric department. As Occupational Health physician, Dr O had expertise in occupational health issues. They were entitled to express the opinion, if that was the opinion that they honestly held, that the psychiatrists’ opinions had not fully taken all the issues into account. They were not only entitled to express their views to each other, but it was important that they did so. (Rightly, it has not been suggested that these email exchanges show bad faith.)
82. Further, as the defendant points out, correctly in my opinion, Dr Y was the case manager, and it is an important part of the case manager’s task to take a view as to the appropriate outcome. This Dr Y did, albeit his position was that the actual outcome should be determined by the ill health panel
83. As I have stated, the particular misgivings as regards Dr Mbaya appear to have been because his previous diagnosis was out of line with previous ones. However, it seems likely that this reflected the material with which he had been provided. On 10 March 2010, having been given more information, he provided a further report and this time diagnosed bipolar disorder, saying that the claimant’s presentation in February/March 2009 was consistent with a hypomanic episode. He considered that it was spontaneous and that the claimant was rapidly cycling between hypomania/mania and depression. He concluded however that the claimant could return to work on a graded return so long as her treatment was supervised by a consultant psychiatrist.
84. He was not alone in this view. Similar conclusions were expressed at this time by Dr RN Chitty, a Consultant Psychiatrist, for the GMC. He concluded that though she was currently well, she was prone to relapse. She needed “to be followed up by a consultant psychiatrist, in the long-term, in order to monitor her mental state and maintain her current wellness by treating her with appropriate mood stabilising medication, prophylactically. It is important that she continues to be monitored in the long-term by a consultant psychiatrist because in the past when her consultant psychiatrist, Dr Muruganathan, retired, she stopped taking the medication that she was on at the time.”
85. There ensued over the next few months disputes between the parties’ respective solicitors in correspondence concerning the appropriateness of instructing a further expert, the choice of expert, and as to disclosure of the claimant’s medical records to the expert. It was eventually agreed that a Consultant Psychiatrist called Dr Adrienne

Reveley would be jointly instructed by the parties' solicitors to review the claimant's condition, and this was done by letter dated 18 October 2010.

86. Meanwhile, in July 2010 the claimant began proceedings in the Industrial Tribunal claiming discrimination on the grounds of disability (in respect of which compensation is uncapped). I am told that this was necessary to remain within time limits, and that those proceedings are presently stayed by consent.

***Dr Reveley's report***

87. On 3 January 2011, Dr Reveley provided a detailed psychiatric report, which details much of the earlier history, though it deals more briefly with the events of February/March 2009 by way of reference to the investigation report. Dr Reveley confirmed the diagnosis of bipolar disorder, stating that the claimant had suffered psychotic symptoms when depressed. She concluded as follows:

“82 Most people with Bipolar Disorder will return to a fully functioning level between episodes and are able to contribute successfully in their chosen career. However, there is a tendency for the illness to worsen as the person ages. Episodes become longer, and the period between episodes shortens. It is extremely important for the individual to take mood stabilising medication and to be monitored on a regular basis.

83. Overall, in my opinion [the claimant's] presentation has been slightly unusual, in that her “manic” phase is overwhelmingly that of irritability, rather than elevated mood, and because she has suffered mixed mood states. It appears that she has been psychotic both when depressed and went in a mixed mood state, but she has responded well to treatment. [The claimant's] condition appears to respond well to mood stabilising and other medication, and in my opinion her prognosis is reasonably good and she is likely to be able to continue to work as a paediatrician if she complies fully with medication and any other treatment recommendations.

84. In my opinion the most serious problem that [the claimant] faces is her grudging insight into her condition. She is currently mentally well, and although she pays lip service to the diagnosis of Bipolar Disorder it is clear that she does not fully accept this, and she tends to minimise or deny her previous symptomatology. In my opinion there is a considerable risk of a further episode and when [the claimant] becomes unwell again, it is likely that her lack of insight will be complete. This is very unfortunate because her condition is otherwise psychiatrically manageable, of only moderate intensity, and she has had long periods when she is well. However, her lack insight means that she will require strict monitoring with procedures in place to ensure that (a) she remains well and (b) any deterioration is quickly identified.

85. I am asked a series of question in relation to [the claimant's] condition. I have reviewed her relevant medical and psychiatric history above, have made the diagnosis of Bipolar Disorder, currently in remission. I have outlined [the claimant's] prognosis, highlighting her lack of insight which I consider to be the most important problem. In my opinion, considering areas of disagreement over the diagnosis in previous reports, particularly the initial report of Dr

Mbaya, it is very important that, when [the claimant] is assessed, the psychiatrist has access to the full medical notes, including the notes from Cheadle Royal. It is noteworthy that, when I went over some of the notes and reports with [the claimant], she continues to dispute their veracity and in my opinion this is a significant indication of her lack of insight.

86. I am asked to consider any assistance which would allow [the claimant] to return to work. In my opinion, it would be a pity if [the claimant's] training and her obvious skills were lost to medicine. I consider that whether she works part-time or full-time is much less important than the process of regular monitoring and support. In my opinion she could work full-time. However her employment should be conditional upon regular updating reports from her consultant psychiatrist being received by Occupational Health. Such reports should be received on a 3 monthly basis initially, perhaps moving to 6 monthly or yearly, depending on [the claimant's] condition. She would benefit from ongoing supervision by the GMC in addition. In my opinion, [the claimant] would also benefit from mentoring by the Trust, as an additional safeguard to ensure that she remains well. It appears that clinical paediatric cases involving the Police are worrying for [the claimant] and she may need additional support with regard to such cases.

87. I do not have the expertise to comment on [the claimant's] clinical skills as a paediatrician, but it appears from her curriculum vitae that she is well qualified to be a consultant paediatrician. However, in my experience, individuals such as [the claimant], who lack full insight into their condition, are often best supported in sub-consultant positions where their day-to-day functioning can be more easily monitored, where they are not in a clinical leadership role, and where mentoring is routine. [The claimant] may find it extremely difficult to accept such a role but in my opinion it would be in her best interest, long-term, for her to work in this way."

88. It is a lengthy, nuanced and careful report, and in my view it is difficult to see that a psychiatric assessment can be taken any further on the presently available material. (I am satisfied that this is not a case where the defendant was contractually obliged to refer matters to an NCAS assessment panel, since clinical competence is not an issue.) I note that Dr Waring agrees with Dr Reveley's views, albeit he is speaking as the claimant's treating psychiatrist.
89. In her witness statement, the claimant accepts that it has not been easy to come to terms with the realisation that she has bipolar disorder. She says she realises that one of the difficulties with the condition is that it causes mood swings between mania and depression and the severity of the symptoms can vary considerably from time to another. She says that having reflected on the documents she has now seen, it is her view that during late 2007 and into 2008, she became unwell intermittently, "but the symptoms I was displaying were less severe than those that followed in early 2009, when I became seriously unwell". She says that after the GMC restrictions were lifted, she hoped she had recovered. With hindsight, she says, she can see that was a mistake for her to be no longer under the regular treatment of a psychiatrist and to have stopped taking medication.

90. I should add that, having heard the claimant testify, from a non-technical perspective it appears to me that Dr Reveley is right in saying that the most serious problem that the claimant faces is her “grudging insight” into her condition. That emerged more clearly from her oral evidence than from her witness statement. In cross-examination, she said that she had accepted the diagnosis of bipolar disorder since 2000, which the evidence shows is not the case. Despite the opinion of Dr Reveley and other psychiatrists, she said that she had never been psychotic, though she accepted that she had been very unwell. She did however say that she was working to improve her insight, and I accept that this is so.
91. On 11 February 2011, the claimant and her solicitors indicated that they were in agreement with the “reasonable adjustments” identified in paragraph 86 of the report. She indicated to Dr Reveley that she would like to address the matter of insight. Dr Reveley replied to the effect that she had seen the claimant on one occasion only, and it would be necessary to discuss and consider insight with the doctors who were treating her.
92. For its part, the Trust wished to discuss matters with the other paediatric consultants. There was some sensitivity on the claimant’s part as to the information with which they should be provided, and further discussion ensued in that regard. Meanwhile, the claimant’s exclusion continued to be reviewed and maintained.
93. The Trust raised further matters with Dr Reveley by letter of 4 April 2011, including clarification as to mentoring, monitoring, and the possibility of a sub-consultant post. At about the same time, the claimant’s solicitors raised issues of their own.
94. The responses are as follows. By letter of 11 May 2011, Dr Reveley wrote to the claimant’s solicitors:

“... In my opinion [the claimant] may find that, long-term, she can work best in sub-consultant role. Bipolar Disorder is a relapsing condition and further episodes of illness are likely. However I understand that [the claimant] wishes to return to work, in the first instance, as a consultant paediatrician and I think it would be appropriate for her to resume work as a consultant, given monitoring and mentoring arrangements.

In my opinion [the claimant] should be followed up by a consultant psychiatrist, particularly if she is going to work as a consultant paediatrician herself. It may be that this monitoring is required by the GMC for a given period of time but, I also feel that the Trust’s Occupational Health should receive regular updating reports from a consultant psychiatrist on a regular basis, to ensure that she takes any medication recommended by her psychiatrist, and to ensure that the issue of insight is kept under review. This is because it is possible that [the claimant’s] Bipolar Disorder may not relapse for several years and if the GMC monitoring has ended (in my experience GMC monitoring is usually only for a number of years) then she might become unwell while she is unmonitored, and because she lacks insight, [the claimant] might not seek help. This might cause particular difficulties if she is working in a supervisory capacity as a consultant paediatrician.

Thank you for sending me the NCAS documentation. [The claimant] will need a return to work programme, in my opinion. However, I do not consider that it will be necessary, ultimately, for her to have any particular modifications to her role apart perhaps from avoiding Police work which has triggered a relapse in the past.

In my opinion the security planning outlines on page 24 of the document will be important. From my interview with [the claimant], one of the problems appears to be that she, herself, does not know when she is becoming unwell. For this reason, it will be important for close colleagues to be involved.

It can often be very difficult for a highly skilled professional such as [the claimant] to accept that they do have a permanent vulnerability to mental health problems, and are liable to become unwell in future. It has been difficult for [the claimant] to accept her past history, and it may be difficult for her to accept that she is liable to future breakdowns, and to accept being monitored and mentored while her colleagues don't have to undergo such procedures. It would be a pity if such feelings prevent her from returning to work in a job where she has considerable training and expertise and I do hope she accepts appropriate measures."

95. By letter also dated 11 May 2011, Dr Reveley wrote to the defendant's solicitors in similar terms as follows:

"... I am pleased that [the claimant] has confirmed that she would like the Trust to consider the adjustments I recommended in my report dated 3.1.11. You have asked for clarification on the level of mentoring and monitoring required.

The mentoring you suggest, with an internal mentor outside of the practitioner's faculty and a clinical mentor from the practitioner's specialism sounds appropriate. I note that [the claimant] would also be able to access support from the Trust's Occupational Health Service. In my opinion no additional mentoring above that described is necessary.

Thank you for the copy of [the claimant's] job plan. I note that [the claimant] would be required to work independently as well as supervising others. As long as she is psychiatrically well, then I foresee no problems with her fulfilling her job description. When [the claimant] is well she is likely to function as effectively and reliably as any other paediatrician.

I do not consider that she would need to be closely supervised when carrying out any of her duties or responsibilities except in one specific area; in my opinion paediatric cases involving the Police are particularly worrying for [the claimant] and if such cases can be avoided that would be helpful. Other than that I think she could carry out the listed PAs without immediate supervision or any special arrangements being made.

However, as I expressed in my report, the fundamental difficulty in [the claimant's] case is her relative lack of insight which has led to a failure to

seek help when she has been becoming unwell and her failure to recognise and accept her illness. In my opinion [the claimant] requires psychiatric monitoring to ensure that she is well, to ensure that she takes any medication recommended, and to ensure that the issue of insight is kept under review. As I expressed in my report, I consider that her employment should be conditional upon regular updating reports from a consultant psychiatrist on a regular basis.

I understand that [the claimant] is not willing to consider a sub-consultant role “at this juncture” nor is there such a position available in the Department. However, I understand that an Associate Specialist role might be arranged and I have considered that Job Description, which I think would be suitable for her.

However at this point, in my opinion, subject to [the claimant’s] treating consultant’s advice as to her psychiatric condition and level of insight, it would be appropriate for her to return to work as a consultant. If there are further problems then I think she will have to accept that she is best suited to a role where she does not have overall responsibility.”

***The August 2011 management report***

96. It was now up to the parties to take matters forward in the light of Dr Reveley’s report, and her subsequent letters. The claimant was not prepared to have the report given to her fellow consultants. What they saw was only a page from the conclusions redacted in part.
97. Over the next two months, various of the paediatricians in the department wrote to Dr Y expressing their concerns as to the prospect of the claimant’s return to work. He is criticised on behalf of the claimant for not seeking a meeting with her at this time to get her views. The defendant’s response is that the parties’ dialogue was by now exclusively through solicitors—given the tone of the correspondence that I have seen, this may be an understandable reaction. On the other hand, Dr Reveley’s report had been jointly commissioned, and if her recommendations were to have a chance of working, ascertaining the claimant’s response was going to be important. I have not been taken to any evidence that a meeting was proposed at this time, though later in the year, *after* Dr Y had reported, a meeting was offered by the defendant, albeit tentatively, but refused by the claimant. Despite the difficulties faced by the Trust, I consider that more should have been done to engage with her at this time.
98. A more general point is made on behalf of the claimant, which is that she “is left with the impression that Dr Y was attempting to gain evidence to justify that which he was going to do all along if Dr Reveley did not support the defendant: not have the claimant back on any terms and Dr Y utilised that time to build this picture against the claimant’s return, rather than fulfil his obligations to take all reasonably practicable steps to return the claimant to work by way of effecting reasonable adjustments”.
99. It is unclear on what basis this allegation is made, and I reject it. In this regard, there is a letter dated 29 July 2011 to Dr Y from Dr N, who as stated, is the Clinical Director of the Paediatric Department. This runs to some 8 pages. I quote from his letter (which is attached to the report that Dr Y subsequently wrote) because, leaving

aside the justification for the points he made—which are strongly contested by the claimant—it is necessary to appreciate the material that Dr Y was receiving at this time, because it explains his response.

100. Dr N expresses doubts as to whether it would be feasible for someone to watch over the claimant and monitor her. He says that the department does not have the resources and expertise for this. He raises in particular the issue of safeguarding responsibilities, and does not believe that these could be eliminated from the workload of a paediatric consultant. It would not be possible to allow the claimant, in his view, to avoid cases with police involvement. Approximately 10 percent of the children seen in the paediatric department will have some inquiries made regarding safeguarding.
101. Dr N said, “The role of a consultant paediatrician is stressful; it is primarily emergency work in a busy emotive environment. In [the claimant’s] case she [Dr Reveley] has identified that cases involving the Police (safeguarding issues) act as a stressor. If these duties cannot be removed then this poses a considerable risk to patient safety and [the claimant’s] health. If, during a period when [the claimant] was the only consultant available e.g. at clinic, or ward rounds or on call and was confronted with a situation involving a potential safeguarding issue, there may be a temptation for her not to report it as a safeguarding issue to avoid becoming involved with other agencies/the Police. This is a huge concern for me in that this would pose an enormous risk to patients and to the Trust generally. I am not in any way suggesting that this has happened but it could happen because of the nature of the circumstances. I do not think that this risk could be properly managed.”
102. By letter of 3 August 2011, Dr Y wrote to NCAS enclosing a management report, with (as I have said) this letter attached. In that report, Dr Y said that he had considered the relevant material. He was of the view that parts of Dr Reveley’s reports were contradictory in so far as she recommended in her first report that strict monitoring was required, subsequently stating that she did not consider that the claimant would need to be closely supervised.
103. I think there is some force in the point made on behalf of the claimant that monitoring is elided with supervision in this respect. It is clear that Dr Reveley was recommending that because of her lack of insight the claimant would need to be strictly monitored for signs of a relapse. On the other hand, Dr Reveley also said that the prognosis was reasonably good, and provided that the recommendations as to treatment were followed, she was likely to be able to continue to work as a paediatrician. She was not suggesting that it would be necessary for someone to “watch over” the claimant in terms of the performance of her clinical duties. (I should however note that, as his witness statement makes clear, Dr K’s view coincides with that of Dr Y as to practicalities in this regard.)
104. Dr Y said:

“...I do not believe that I can require her colleagues to monitor her which a task that they are not trained to do. I also accept that staff, in particular junior staff, are less likely to report any signs of relapse and/or confront [the claimant]. I accept the comments of her colleagues that this leaves the Trust exposed to a risk in the event of [the claimant] suffering a relapse.

Notwithstanding Dr Reveley's comments about monitoring, my view is that on the information available, day to day monitoring would be required to the extent that at the very least another consultant would need to be present when she was working to properly and effectively monitor and support. Whilst this recommendation could be implemented at another Trust with a larger Paediatric Department where there are more consultants available and more than one paediatric consultant on call at any given time, this is not possible in this District General Hospital with a relatively small Paediatric Department."

105. Dr Y concluded as follows:

"I have focussed on the reports from Dr Reveley and the input from Dr N, Clinical Director. In assessing whether or not Dr Reveley's recommendations are feasible, I have considered the following

- how effective the change would be in avoiding the disadvantage that would otherwise be experienced by [the claimant]
- the practicality of the adjustment
- the cost of the adjustment
- the Trust's resources and size of implementing the adjustment
- the availability of financial support to implement the adjustment

I believe that there are intractable problems in the implementing the recommendations and as such, I do not believe that they can be implemented and [the claimant] is not able to return to work."

106. The chief difference between the approach taken by Dr Y and Dr Reveley concerns supervision. Dr Y was of the view that the claimant would require another consultant to be present when she was working. In her letter to him of 11 May 2011 however, Dr Reveley says that she does not consider that the claimant would need to be closely supervised when carrying out any of her duties except in one specific area. In her opinion, paediatric cases involving the Police were particularly worrying for the claimant, and if such cases could be avoided, that would be helpful.

107. On the evidence, I am satisfied that Dr Y's response was influenced by the obvious reluctance of the claimant's colleagues to have her back in the department. On the other hand, whilst the claimant is well, I would say that there seems sense in Dr Reveley's opinion that she would not need to be closely supervised when carrying out her duties.

108. But I do not accept the submission made on behalf of the claimant in closing that to make a link between contacts with the police and safeguarding is "preposterous". There is inevitably a link in the way such cases may need to be dealt with, and I do not consider that this particular part of Dr Reveley's report and subsequent letter can be discounted. Whether or not her opinion is correct, her opinion is plainly intended to constitute a whole, carefully balancing different (and difficult) factors in an effort to provide a recommendation.

109. In any case, I cannot accept the submission that there has been a deliberate distortion of Dr Reveley's views to keep the claimant away from work, and there is no material to support this.

110. In its response by letter of 30 August 2011, NCAS said that if the adjustments were impractical and the required safeguards could not be provided, then it was open for the Trust to refer the matter to a panel to consider termination of the claimant's contract on the grounds of her incapacity. As the Particulars of Claim puts it, this letter was supportive of the Trust's approach, and it was.
111. There was some further correspondence between solicitors, but on 4 October 2011 the Trust's solicitors stated that the decision to proceed to a panel hearing was maintained. A meeting to discuss rehabilitation was not appropriate. They said that the involvement of legal representatives from a relatively early stage had made exchanges more formal, and that the claimant's solicitors had requested that communications be sent to them. However, they said that the possibility of a face to face meeting was not ruled out, and asked if the claimant would like one to be arranged.
112. On 12 October 2011, the claimant's solicitors responded to the effect that there was no merit at all in a further meeting, since Dr Y was "of the fixed view" that her employment should be terminated. It is true that this comes late in the day so far as this claim is concerned, because by that time, Dr Y had reported. However it does not seem to me that a meeting even at this stage would have been meaningless, and the fact that the claimant refused a meeting at this point does (if only to a limited extent) undermine the arguments that have been advanced based on the defendant's failure to hold a meeting, which as I have already said, otherwise have some force.
113. These proceedings were issued on 28 October 2011. On 18 November 2011, the matter came before His Honour Judge Wood QC. Essentially, the hearing went by consent. There was the anonymity order made that I have already referred to. The defendant undertook not to hold a panel meeting until trial. A speedy trial was ordered.

*A new case manager is appointed*

114. On 16 January 2012, because of Dr Y's absence from work due to illness, Dr K was asked by the Trust's Chief Executive to become case manager. As I said earlier, he is a Consultant in intensive care medicine with the Trust. Thereafter, he reviewed all the material in this matter, which is considerable. On 3 February 2012, his appointment was confirmed.
115. By letter of that day, he wrote to the claimant informing her that he had reviewed her exclusion and had decided to continue it subject to allowing her to attend the premises for certain limited purposes. The changes related to a number of things, such as attending for Grand Rounds, and attending for CPD training.
116. Having reviewed the documentation relating to her case, he said that he considered it appropriate for an ill health panel to consider all of the evidence and decide whether or not she (i) should remain in post with adjustments, (ii) be returned to a different role, or (iii) her employment be terminated.
117. It is correct, as is said on her behalf, that this decision was taken without further reference to the claimant. I shall have to consider its impact on the matters I have to decide. For the present, I need only say that Dr K was a good witness, who was

clearly committed to obtaining the right outcome in a very difficult situation (the contrary was not suggested). He was in court for all the oral evidence, and said in re-examination that what he had heard had not changed his mind.

### *The claimant's insight*

118. The defendant invites a finding of fact that the claimant had and has no real insight into her condition. In the alternative, it submits that the position is that it is arguable that she has no insight, and that this is matter for the ill health panel to consider.
119. It appears to me that the question of “insight” in the sense used by the psychiatrists is a matter of expert opinion, and I should not make findings of fact except by reference to it. In reality, there is a large body of evidence as to the claimant’s lack of insight. In her report, Dr Reveley says:

“In terms of her insight, at interview with me [the claimant] tended to be dismissive about the diagnosis of bipolar disorder. Although she verbally accepted the diagnosis, it was apparent that this was because she had to accept it, rather than because she fully understood her condition. [The claimant] often mentioned psychiatric reports which did not confirm the diagnosis of bipolar disorder. She would shrug her shoulders when asked about previous symptomatology. She minimised her previous mental health problems, and at times would deny what was written in the medical notes. When asked directly about previous episodes of mental health problems and difficulties with colleagues, [the claimant] would fall back on her educational attainments and medical skills, as though her general ability as paediatrician negated the presence of any mental disorder. She expresses her willingness to take medication, but would prefer not to do so”.

120. It appears to me that (perhaps not surprisingly) something of this has been reflected in the representations that have been made on the claimant’s behalf over the past three or more years. In particular, the material that I have seen suggests a tendency to minimise the seriousness of the events that led to the claimant’s exclusion in March 2009.

### The MHPS and the Trust’s policy

121. The exclusion of the claimant and the convening of the ill health panel fall within a document issued by the Secretary of State called Maintaining High Professional Standards in the Modern NHS (“MHPS”). How this change came about is set out by Swift J in *Hameed v Central Manchester University Hospitals NHS Foundation Trust* [2010] EWHC 2009 (QB) at paragraphs 60 and following. Part I deals with action when a concern arises, Part II with restriction of practice and exclusion from work, Part III deals with conduct hearings and disciplinary matters, Part IV deals with procedures for dealing with issues of capability, and Part V deals with handling concerns about a practitioner's health.
122. So far as is relevant to this case, the Trust incorporated MHPS in a Policy of Handling Concerns about the Conduct, Performance and Health of Medical Staff (“the Policy”), which is a document issued in October 2007. It is accepted by the defendant that the Policy is incorporated into the claimant’s contract of employment. The defendant

does not however accept that all provisions of MHPS/the Policy are apt for incorporation.

123. The claimant asserts in its Particulars of Claim that the following extracts form the material parts of the Policy (although in the event, the claimant relied on two particular provisions). I make it clear however that, though lengthy, the pleading does not set out the whole procedure by any means, and other provisions which are not pleaded fill out the complete picture.

### **1 Introduction**

The management and performance as a continuous process and [D] will support staff to perform the role is the best of their ability

- health issues are routinely dealt with through the occupational health service

### **2.5 Handling concerns about practitioner's health**

2.5.2 Wherever possible all staff will be treated, rehabilitated or retrained to enable individuals to remain in the employment

2.5.3 **Reasonable adjustments.** Reasonable adjustments will be made to the practitioner's role to support the practitioner remaining in employment..... Some examples are.... Support absence to enable rehabilitation, assessment or treatment

### **3 Procedure**

3.1.1 The case manager will ... contact NCAS for advice, if necessary

### **3.2 Restrictions on practice and exclusion from work**

c) The trust will ensure that:

Exclusion from work is used only as an interim measure whilst action to resolve the problem was being considered

Where a doctor is excluded, it is for the minimum necessary period of time: this can be up to but no more than no more than four weeks at a time

All extensions of exclusions are reviewed and a brief report provided to the Chief Executive and the Board

A detailed report is provided when requested to a single non-executive member of the board (the designated board member) who will be responsible for monitoring the situation until the exclusion has been lifted

### **3.2.2 Managing the risk to patients**

a) When serious concerns were are about a doctor, the trust will give urgent consideration as to whether it is necessary to place at temporary restrictions on his/her practice

b) Exclusion of clinical staff from the workplace is a temporary measure.... Exclusion from work should be reserved for only the most exceptional circumstances

- it is imperative that exclusion from work is not misused or seen as the only course of action that could be taken. The degree of action must depend on the nature and seriousness of the concerns and on the need to protect patients, the Dr concerned and/or their colleagues

### **3.2.3 The exclusion process**

The Trust will not require exclusion of a doctor for more than four weeks at a time. The justification for continued exclusion will be reviewed on a regular basis and before any further four week period of exclusion is imposed. The trust is responsible for ensuring that the process is carried out quickly and fairly, kept under review and that the total period of exclusion is not prolonged

### **3.2.4 Key features of exclusion from work**

An initial immediate exclusion of no more than two weeks if warranted

Notify NCAS before formal exclusion and seek advice on the case management plan

Formal exclusion (if necessary) for periods up to 4 weeks

Appoint a board member to monitor the exclusion and subsequent action

Refer to NCAS for a formal assessment, if part of case management plan

Ensure the right to return to work if the review was carried out

Provide a performance report on the management of the case to the Trust Board

### **3.2.5 Role of officers**

a) The Chief Executive has overall responsibility for managing exclusion procedures and for ensuring that cases are properly managed. The case will be discussed fully with the Chief Executive, the Medical Director, the Director of Human Resources, NCAS and other interested parties ... prior to the decision to exclude the doctor. In the rare cases where immediate exclusion is required, the above discussion of the case will take place at the earliest opportunity following exclusion, preferably at a case conference

### **3.2.6 The role of the designated board member**

Representations may be made to the designated board member in regard to exclusion, or investigation of a case. The designated board member will also ensure, among other matters, that time frames for investigation or exclusion are consistent with the principles of article 6 of the European Convention on Human Rights (which broadly speaking set out the framework of rights to a fair trial)

### **3.2.7 Immediate exclusion**

a) An immediate time limited exclusion may be necessary for the purposes identified paragraph 3.2.1 (c) above following....[there is omitted from the pleading reference to *a critical incident where serious allegations have been made, and where there has been a breakdown in relationships between a colleague and the rest of the team*]

b) such an exclusion will allow a more measured consideration to be undertaken. This period should be used to carry out a preliminary situation analysis, to contact NCAS for advice and to convene a case conference. The manager making the exclusion must explain why the exclusion is being made in broad terms (that may be no formal allegation at this stage) and agree a date up to a maximum of two weeks away, at which the practitioner should return to the workplace for a further meeting. The Case manager will advise the practitioner of his/her rights, including rights of representation

### **3.2.8 Formal Exclusion**

a) A formal exclusion may only take place after the case manager has first considered whether there is a case to answer and then considered, at a case conference, whether there is a reasonable and probable cause to exclude. NCAS will be consulted where formal exclusion is being considered. The case investigator has been appointed he or she must produce a preliminary report as soon as is possible to be available for the case conference. This preliminary report is advisory to enable the case manager to decide on the next steps as appropriate

e) When the doctor is informed of the exclusion, there must be a witness present and the nature of the allegations or areas of concern should be conveyed to the doctor. An explanation will be given as to the reason(s) why formal exclusion is regarded as the only way to deal with the case. At this stage the doctor will be given the opportunity to state his or her case and propose alternatives to exclusion (for example... Referral to NCAS with voluntary restriction)

h) If the case manager considers that the exclusion will need to be extended over a long period outside his/her control (for example because of a police investigation), the case will be referred to NCAS for advice as to whether the case is being handled in the most effective way and suggestions as to possible ways forward. However even during this prolonged period, the principle of four week renewability will be adhered to.

### **3.2.9 Exclusion from premises**

a) A doctor will not be automatically barred from the premises upon exclusion from work. Case managers will consider whether a bar from the premises is absolutely necessary. There are certain circumstances, however, where the doctor should be excluded from the premises. This could be, for example, where there may be a danger of tampering with evidence, or where the doctor may be a serious potential danger to patients or staff. In other circumstances, however, and may be no reason to exclude the doctor from premises. The doctor may want to retain contact with colleagues, take part in clinical audit, remain up to date with developments in the field of practice, undertake research or training. This will be discussed and agreed with the individual

...

b) The case manager will make arrangements to ensure that the doctor can keep contact with colleagues on professional developments, and take part in Continuing Professional Development and clinical audit activities at the same levels of support as other doctors. A mentor will be appointed for this purpose if a colleague is willing to undertake this role

## **3.3 Keeping exclusions under review**

3.3.1 Informing the Board. The Board must be informed about exclusion at the earliest opportunity. The Board has a responsibility to ensure that the Trust's internal procedures are being followed. It will therefore;

- require a summary of the progress of each case at the end of each period of exclusion, demonstrating the procedures are being correctly followed and that all reasonable efforts are being made to bring the situation to an end as quickly as possible

- receive a monthly statistical summary showing all exclusions with the duration and the number of times the exclusion had been reviewed and extended. A copy will be sent to the Strategic Health Authority

### **3.3.2 Regular review**

a) The case manager will review the exclusion for the end of each four week period and report the outcome to the Chief Executive and the Board. This report is advisory and should only contain enough information to satisfy the Board that the procedures are being followed as Board members might be required to sit as members of a future disciplinary panel. The case manager will decide on the next steps as appropriate. The exclusion should usually be lifted and the doctor allowed to work, with or without conditions of employment, at any time the original reasons for exclusion no longer apply and there are other reasons for exclusion

b) The Trust will take review action before the end of each four week period. After three exclusions, NCAS will be called in.....

- The Chief Executive must report to the strategic health authority and the designated board member

- The case must formally be referred to NCAS explaining why continued exclusion is appropriate and what steps are being taken to complete the exclusion at the earliest opportunity

- NCAS will review the case with the SHA and advise the trust on the handling of the case until it is concluded....

- if the exclusion has been extended over six months, a further position report must be made by the Chief Executive to the SHA indicating the reason for continuing the exclusion, anticipated time scales for completing the process and actual or anticipated costs of the exclusion

### **3.3.3 The role of the SHA monitoring exclusions**

b) When an exclusion decision has been extended twice, the Trust's Chief Executive must inform the SHA of what action is proposed to resolve the situation

### **3.3.4 The role of the Board and designated member**

a) the Board has a responsibility for ensuring that these procedures are established and followed. It is also responsible for ensuring the proper corporate governance of the organisation, and for this purpose reports must be made to the Board under this procedure

c) the Board is responsible for designating one of its non-executive members as a "designated board member" under this procedure. The designated board member is the person who oversees the case manager and investigating manager during the investigation process and maintains the momentum of the process

d) this member's responsibilities include - receiving reports and reviewing the doctors continued exclusion from work; - considering any representations from the doctor about his/her exclusion; - considering any representations about the investigation

## **3.5 Conducting capability hearings**

3.5.4 the case manager will:

- decide what further action is necessary following comments from the practitioner and advice from NCAS
- consider whether an action under 3.2 of the procedure is necessary to exclude the practitioner or place a temporary restriction on their duties
- consider with the medical director and director of human resources whether the issue(s) can be resolved through local action, eg retraining, counselling etc
- refer the case to NCAS if local action is not practicable solution. NCAS will consider whether an assessment should be carried out to support an action plan
- inform the practitioner of the decision about the next steps
- facilitate discussion between the Trust, NCAS and the practitioner in drawing up an action plan to remedy any lack of capability identified during the assessment process
- inform the practitioner that the case will proceed directly to a capability hearing if the assessment process concludes that the practitioner's performance is so fundamentally flawed no educational and/or organisational action plan would succeed
- inform the practitioner that the case will go directly to a capability hearing if they do not agree to the case being referred to NCAS

### **3.6 Handling health issues**

3.6.1 The case investigator will provide a report to the case manager, which may point to a problem with the practitioner's health

3.6.2. The case manager will refer the practitioner to the occupational health service for assessment

3.6.3 NCAS will also be consulted for advice before proceeding further

3.6.4 The report from the occupational health service will be sent to the medical director, who will meet with the practitioner to agree a timetable of action and rehabilitation (where appropriate). The practitioner may wish to bring a friend/colleague or representative to this meeting. The director of human resources will also be present

3.6.5 If the practitioner's ill-health makes them a danger to service users and they do not wish to co-operate with measures to protect patients, they will be excluded from work and the GMC will be informed

3.6.6 If a practitioner, subject to disciplinary proceedings, put forward a case on health grounds to delay the proceedings, the Trust will refer the practitioner to the occupational health service for assessment

124. Further, the claimant pleads that the following parts of MHPS formed part of her contract of employment, or were impliedly incorporated into it, or incorporated by virtue of the implied term of mutual trust and confidence.

### **PART V handling concerns about a practitioner's health**

1. A wide variety of health problems can have an impact on an individual's clinical performance. These conditions may arise spontaneously or be as a consequence of work place factors such as stress

2. The principle for dealing with individuals with health problems is that, wherever possible and consistent with reasonable public protection they should be treated, rehabilitated or retrained (for example if they cannot undertake exposure prone procedures) and kept in employment, rather than be lost from the NHS

### **Retaining the services of individuals with health problems**

3. Wherever possible the Trust should attempt to continue to employ the individual provided this does not place patients or colleagues at risk.

Examples of actions to take..... arrange retraining or adjustments to the working environment, with appropriate advice from NCAS.... under reasonable adjustment provision in the Disability Discrimination Act 1995

### **Reasonable Adjustment**

4. At all times the practitioner should be supported by the employer and the occupational health service who should ensure that the practitioner is offered every available resource to get back to practice where appropriate. Employers should consider what reasonable adjustments could be made to the workplace conditions or other arrangements.

Reasonable adjustments include..... Allow absence for rehabilitation, assessment or treatment.... establish mentoring arrangements

### **Handling health issues**

7. NCAS should be approached to offer advice on any situation at any point where the employer is concerned about a doctor or dentist. Even apparently simple or early concerns should be referred as these are easier to deal with before they escalate.

8. The occupational physician should agree a course of action with the practitioner and send his/her recommendations to the medical director and a meeting should be convened with the director or head of HR, medical director or case manager, the practitioner and caseworker from the OHS to agree a timetable of action and rehabilitation (where appropriate). The practitioner may wish to bring a support companion to these meetings. This could be a family member, colleague or a trade union or defence association representative. Confidentiality must be maintained by all parties at all times.

9. If a doctor's ill health makes them a danger to patients and they do not recognise that, or are not prepared to co-operate with measures to protect patients, then exclusion from work must be considered and the professional regulatory body must be informed, irrespective of whether or not they have retired on grounds of ill-health.

10. In those cases where there is impairment performance solely due to ill-health, disciplinary procedures would only be considered in the most exceptional of circumstances, for example if the individual concerned refuses to cooperate with the employer to resolve the underlying situation e.g. repeatedly refusing a referral to the occupational health service or to NCAS. In these circumstances the procedures in part IV should be followed.

### The parties' submissions

#### ***The claimant's submissions***

125. I set out here the claimant's submissions from the summary in her written closing submissions. So far as these are based on factual assertions, I have largely dealt with them in my findings of fact set out above.
126. The claimant alleges that her contract of employment has been breached, or will be breached. She relies on express terms of the contract in relation to the all important power to exclude and the concomitant duty regularly to review her exclusion. The defendant has breached those provisions on an extensive basis commencing with the claimant's first exclusion. The exclusion powers cannot be seen in isolation. They are part of the essential architecture whereby pro-active steps are to be taken by the defendant to assist the claimant to return to work.
127. The express provisions are also relied on by the claimant in respect of its handling of her ill health absence are the 2.5 and 3.6 procedures of the Policy. Specifically, 3.6 expressly obliges the defendant to take essential steps to cooperate and work with the claimant to attempt to resolve the issues which have kept her excluded. The absence of a panel (or any reference in MHPS to a panel) is striking. This is a collaborative process where the employer is to work with the employee to assist, where practicable, the employee to return to work. A panel is not envisaged because if the employer cooperates, any formality (whatever that is) is unnecessary.
128. The claimant alleges the defendant breached its own procedures (on ill health absences) in that having elected to take independent expert advice, it failed in its most basic of tasks under the procedure in engaging the claimant to see if matters could be resolved (para 3.6.4).
129. Any decision to reject the expert advice commissioned required a minimum engagement of a meeting with the claimant. The suggestion made during the hearing that a meeting was offered is formally correct but substantively wrong. An offer of a meaningless meeting was made post the Management Report when the defendant had decided (as it had threatened since November 2009) that (a) Dr Reveley's report was to be rejected (b) no reasonable adjustments could be effected (c) the claimant should be dismissed "albeit dressed up as a recommendation to a panel. That should be seen as an attempt to cloak the decision with some post event semblance of formality and fairness".
130. On any view NCAS, which ought to be pivotal, was kept at arm's length. They should have been called into assist and they were not. NCAS as a very minimum procedural safeguard ought to have been consulted by Dr K before his 3 February 2012 decision. He did not, and there is no explanation/ justification for this. It plainly is a breach of the procedure. Even when he did contact NCAS, he did not consult them, he merely informed them of his decision.
131. The duty to cooperate with the claimant and take steps to see if a return to work can be effected (as the procedure contemplates) has similarly been breached. On receipt of Dr Mbaya's report there was a duty to engage with the claimant. Nothing of the sort was attempted. The defendant appears simply to have ignored that report because it did not find it to its liking.
132. The decision to seek another expert medical opinion is of importance. The defendant was seeking this again because it was outside its speciality and it needed guidance.

Whilst that did not prevent it from not accepting the advice in the event of it being irrational or manifestly wrong, if an employer seeks such advice and receives it, it should as a matter of the fair conduct of its procedure, investigate with the expert and the claimant to what extent the report can be implemented, rather the complete opposite here. Moreover, if the employer is to reject the advice it has commissioned, it must do so (as a matter of fairness by way of the express procedure or by way of the implied duty of good faith) on a proper reasoned basis whilst being fair to the claimant. None of this was carried out by the defendant.

133. The objection in respect of monitoring is a crude misrepresentation of matters. Monitoring is wrongly elided with supervision (which plainly was only a GMC matter). The level of supervision was made clear by Dr Reveley, that is, the claimant could work independently save it would be helpful if cases involving the Police could be avoided. On any view, the claimant submits, that would be a matter to be worked out between the parties as a reasonable adjustment and not a fundamental obstacle to her returning.
134. The supervision suggested by the defendant is in effect shadowing. This is not what any psychiatrist has ever said this was sense necessary. Nor would they, as it would involve the claimant being constantly monitored which would mean she was not fit to practice. The position is no different to what obtained in late 2005 when nobody suggested that such arrangements be in place. The regulator (the GMC) who is the first guardian of the public's welfare, does not recognise this. As the defendant well knows, remedial supervision is often adopted for poor clinical performance and that in no sense involves the measures that the defendant suggests needs to be taken. The claimant is entitled to ask the question: if this is not required for an incompetent doctor, why should it be required for a competent doctor who is well? The answer may well be that it is used to frustrate her return. The defendant never raised any such concerns before. It plainly is trying to tie in the risk of relapse with the need for shadowing. But that is wholly misconceived approach. The claimant has never suffered a catastrophic relapse (as the defendant infers by seeking such measures) as the pattern of her medical decline is gradual and cumulative. In other words, it is an objection without any foundation and a proposal that is irrational.
135. The defendant appears to have ignored the clear guidance and manifestly applicable help as set out at various NHS publications. The case study of Dr Leyton (a hypothetical paediatrician with bipolar disorder) is wholly on point and demonstrates fair and reasonable practice.
136. If Dr Y thought Dr Reveley was contradicting herself, then all the more reason to revert to her. That was not done nor is it explained why it was not done.
137. The same applies in relation to police cases. Again the claimant submits that this is being converted into something it is not. Dr Reveley only made reference to police cases and the advisability of adopting a strategy that the claimant avoids cases involving the Police. She has not said that the claimant cannot have any dealings with the Police not least when she is well. The defendant, again, is attempting to make too much of this. Safeguarding is not mentioned by Dr Reveley at all. Dr Y, for reasons not explained, has sought to raise the issue of safeguarding and has suggested that, based on what Dr N states in his various contributions. Safeguarding of children self-evidently is a feature of being a consultant paediatrician. That involves looking after

children's welfare as Dr N observes. That is principally is a matter, when there is an issue, for agencies such as local authorities under the Children Act 1989. To suggest that the claimant cannot do her job because she cannot have contact with the Police and that is intimately connected with safeguarding is preposterous.

138. Self evidently, working out the precise parameters of the claimant's job on a return to work is a matter of cooperation, flexibility and understanding. To regard it is an absolute bar when it has not been raised with the claimant is fundamentally wrong.
139. The independent decision of Dr K on any view was a breach of contract in itself. He was obviously deployed by the defendant to repair any perceived damage to its case. Rather than making things better, it has made things worse for the defendant.
140. All the above deal almost exclusively with express duties the claimant enjoyed. The role of the implied term of trust and confidence has an important role to play in this case. This is on the basis (a) there have been freestanding breaches of the term in itself e.g. breach of procedure or principles of fairness (b) the flexible use of the implied in the last straw doctrine which allows a cumulative view to be taken of all relevant events, and the court to assess whether events closer to the end of the factual matrix materially contribute to a breach of the term.
141. The claimant relies on the following examples of breaches (in addition to the breaches identified above) of the implied term, either individually or cumulatively as follows:
  - i) The failure of the defendant to monitor and look out for her interests once taken on. Contrary to the Department of Health guidance, the defendant's pre-employment anxieties about the claimant's vulnerability, were not matched by any steps to continue to look out for her welfare whilst in employment;
  - ii) The draft report dated 29 May 2008 and conclusions;
  - iii) The failure to address or act on the report and manifestly the problems that the claimant's developing illness was having on her working environment and working relations;
  - iv) The whole exclusion process;
  - v) The handling and treatment of Dr Mbaya;
  - vi) The movement and proposal to terminate the claimant's employment at such a nascent stage in the whole proceedings, that is, 25 November 2009;
  - vii) The plainly inappropriate and unacceptable preference for only psychiatric evidence to be accepted that concurred with the defendant's wholly unacceptable view that nothing should be done to return the claimant to work. The exchange of emails on 5 March 2010 has never been explained by the defendant. A fair reading is that the defendant was going through the motions in the hope of finding a report that accepted its closed mind approach;
  - viii) The treatment then of (a) Dr Reveley and her report (b) of the claimant, were further individual insults to the implied term in themselves;

- ix) The failure to observe ordinary principles of fairness in relation to the production of the Management Report in August (not least consultation with the claimant's colleagues and not the claimant; the disclosure of parts of Dr Reveley report without her consent) compound matters;
  - x) The movement then to hold a panel hearing at which the employer will say it cannot make adjustments therefore the claimant must be dismissed, is a freestanding or cumulative complaint. The utterly meaningless and hollow gesture of a meeting with Dr Y in no sense cloaks this conducts with any sense of reasonableness let alone fairness;
  - xi) The continued breaches post August 2011 in respect of exclusion (review and terms and consideration) adds to the sense of grievance;
  - xii) The decision of Dr K, whilst independent breaches of express contractual procedures in themselves, make matters much worse for the defendant.
142. As regards the Ill Health Panel, there is no contractual procedure for this in respect of ill health. This is not strictly the type of case (as argued by the defendant) whereby the employer elects between two competing courses of action because the contract permits it. Here the contract entirely silent on such a panel as is MHPS. The question therefore is not whether the employer exercises a discretion correctly, but whether there is a lawful contractual basis to do this in the first place and even if there is, whether the employer is acting lawfully and proposing to do so.
143. The defendant points to no contractual power to permit it to proceed as it suggests. The most one can see is the 25 November 2009 letter stating that the defendant is proceeding by "analogy". Analogy does not make for a contractual right, and the defendant must first locate the power to convene.
144. The absence of a panel reference in MHPS or the contractual procedures is key, as is the reference to meetings. This contemplates a consensus/ collaborative based approach to the dealing with absences caused through illness. That position becomes even stronger when the absent doctor has a disability where there is a legal duty, if appropriate, to make reasonable adjustments. That duty, properly understood, is one of positive discrimination i.e. treat the disabled person more favourably than others. The obvious reason for this is that social/legal policy rightly dictates that such vulnerable people should be helped to integrate into mainstream society.
145. The claimant's case is that the duty of protection and proactivity towards her was not observed after she was employed. The claimant of course accepts she may not have helped herself. But, that cannot possibly absolve an employer, an employer with the defendant's knowledge and resources, from taking essential steps to help and intervene. In that regard, reference is made to the Department of Health guidance in determining good practice and what obligations the defendant enjoys: that is, Mental Health and Ill Health in Doctors issued in February 2008 and also NHS employers – mental health and employment in the NHS issued in October 2008, and Good Practice and Guidance of 5 March 2010.
146. The emphasis on stigma having an internal pressure on doctors not to report or acknowledge mental health issues (insight in effect) have a resonance and

applicability in this case: it helps to explain the claimant's difficulties in coming to terms with her condition and it clearly identifies the burden on the employer to be proactive.

147. The above good practice (and therefore an implied term of the contract as it is a feature of duty to act fairly) must be viewed from before the claimant's employment commenced. It is instructive to see the steps the defendant took (exhaustive the claimant suggests) to ensure that the claimant would be able to do her job. That also enjoined her line manager and the defendant to in effect "keep an eye on her". That was because the claimant was vulnerable and had a relapsing condition. Mood changes were identified by her line manager as being critical and yet nothing was done.
148. When Ms HRT was stressing prior to employment that the claimant's safety was paramount, that appears to have been forgotten when she was employed i.e. the defendant's objections to employing her in the first place were removed. There is no evidence they did anything of the sort. There is the clearest evidence that the defendant was confronted with mood changes and challenging workplace circumstances in 2008. That that led to the provisional report could not be clearer and was accepted by the claimant in June 2008. There is no good reason why the defendant never acted on this report (which was redolent of what Dr N had been so concerned about in May 2005 i.e. behavioural and mood changes).
149. The claimant appears to have been left without any of the support or intervention that the good practice guidance contemplates, not least in relation to colleagues keeping an eye on her. The duty of pro-activity and the obligation to collaborate has manifestly not been honoured by the defendant.
150. The cumulative effect of the above, the claimant submits, is that the defendant's decisions in August 2011 and February 2012 manifestly were a breach of contract.

### ***The defendant's submissions***

151. I set out here the defendant's submissions from the summary in its written closing submissions. So far as these are based on factual assertions, I have dealt with them in my findings of fact set out above.
152. It is inappropriate to grant an injunction or any relief. No damages are sought by the claimant. It remains unclear what is truly being sought by the claimant and why an injunction to restrain the holding of an ill health panel is appropriate.
153. It is inappropriate for the following reasons. Whether advanced as a mandatory injunction, specific performance or a negative injunction the court should be very slow to intervene in a contract for the provision of personal services.
154. Although dressed as a negative injunction, the application is for specific performance or for a mandatory injunction for the defendant to make adjustments and return the claimant to work. The alternative is that it leaves the matter without any resolution. In such circumstances it would enjoin the defendant from proceeding with its consideration at an ill health panel of what is to happen without specifying what the

defendant should then do to resolve the matter and leave the claimant lawfully excluded.

155. It would have the effect of the court:-

- i) Ordering the defendant to make reasonable adjustments, which is a matter for the defendant to consider;
- ii) Assessing the reasonableness of those adjustments, a matter for the employer and if necessary the Employment Tribunal;
- iii) On the case advanced by the claimant, requiring the defendant to return her to work;
- iv) Taking on the mantle of the employer and determining what adjustments to make.

156. The interests of the public and patient safety require the defendant to properly consider whether it is appropriate to return the claimant to work and if so with what adjustments. That requirement is met by the ill health panel. The claimant seeks to enjoin the defendant, the employer, from making a decision as to what is to happen before it has made any such decision, when:

- i) There is an internal procedure to determine what is to happen, the ill health panel at which the claimant will be legally represented;
- ii) There is a clear basis for the defendant to make a decision as to what is to happen, balancing the interests of the parties and the public;
- iii) The decision to refer the matter to an ill health panel is an exercise of discretion, which can only be challenged on grounds of irrationality and no grounds have been identified or advanced.

157. It remains unclear what breaches the claimant is alleging in support of her application for an injunction. In any event there have been no breaches that could support such an injunction:

- i) There has been no breach of the implied term of trust and confidence;
- ii) The expression of a view by the case manager as to what he thinks should happen is the function of the case manager and cannot be a breach;
- iii) At the very least such an expression of view cannot be a breach unless it is expressed in bad faith or perversely;
- iv) The obligation to make reasonable adjustments is not (as the claimant concedes) an express contractual requirement;
- v) There has been no failure to make reasonable adjustments and there can be no question of anticipatory breach in respect of any requirement to make reasonable adjustments: the question of whether or not adjustments can be

made to allow the claimant to return to work has yet to be considered by an ill health panel and there is no certainty as to its conclusion on that matter;

- vi) The decision to refer to an ill health panel is not in breach of contract and the claimant has failed to identify a clause of the claimant's contract with the defendant that a referral to an ill health panel can be said to breach;
  - vii) The decision as to whether or not the claimant can be returned to work and with what adjustments and the decision to whether these issues need to be considered by an ill health panel are decisions for the defendant to consider;
  - viii) The decision can only be challenged on the grounds that the defendant has acted irrationally or that the defendant has unlawfully taken account of something that it should not have taken account of. Nothing in the documentation or oral evidence supports such a finding and as above no such irrationality has been identified.
158. The claimant has a claim in the Employment Tribunal and can bring a further claim for uncapped compensation should the defendant unlawfully fail to make reasonable adjustments.
159. No separate relief is sought in respect of the exclusion. None would be appropriate. The claimant's exclusion is not relied upon to grant the injunction. Rather it is said to be evidence of the defendant's approach and supports the alleged breach of the implied term.
160. The claimant accepted (through her counsel) that the defendant had reasonable and proper cause to exclude her (Paragraph 3.2.8 a) and that the extent of her exclusion, as modified in February 2012 by Dr K, is appropriate.
161. The paragraphs of the defendant's policy relied upon by the claimant are not apt for incorporation. They are guidance as to best practice. If they were regarded as contractual then breaches would lead to the Court micro-managing the defendant, as particularly illustrated by the evidence of Ms HRT given under cross examination. To the extent that they are apt for incorporation (which is not accepted) any breach is de minimis.

## Discussion and conclusions

### ***Introduction***

162. It is necessary to begin by reference to the relief sought by the claimant. In her opening submissions, it is summarised as follows. Through "the various routes identified, (a) breach of implied term of trust and confidence (whether individually or cumulatively) (b) breach of enforceable contractual procedures, the claimant submits that the defendant in proposing to convene the ill health panel hearing, is acting in breach of contract. The claimant will invite the court to (a) make a declaration to this effect (b) grant the remedy of injunction preventing this hearing unless and until the defendant fulfils its contractual obligations to the claimant". This corresponds with the claimant's pleaded case. (I shall come back to the claimant's case as to the

practical steps that would need to follow if an injunction or declaration to the same effect is granted.)

163. The particular point made by the defendant at trial was that, whether or not there have been breaches of the procedure as to exclusion, or otherwise, and whatever views may have been expressed by the defendant in the past, it would be wrong for the court to intervene to prevent an independent ill health panel from considering all of the evidence and deciding between the alternatives set out in Dr K's letter of 3 February 2012, namely whether or not the claimant (i) should remain in post with adjustments, (ii) be returned to a different role, or (iii) her employment be terminated.
164. The claimant's case is put somewhat differently in her closing submissions, no doubt to meet this point. It is said that the "claimant invites the court first to consider whether there has been any breach of contract. If there has, the court is invited to make a declaration to that effect. The court's declaration ought to be sufficient to resolve matters between the parties, subject to dealing with the defendant's argument that the claimant's claim for relief somehow amounts to specific performance through the back door. In the alternative, the claimant seeks an order preventing the defendant from convening an ill health panel based on (a) the Dr Y report of August 2011 (b) the Dr K decision of 3 February 2012".
165. It is clear that the nature of the claimant's case in these proceedings has been for an injunction to stop the convening of the ill health panel, or a declaration to the same effect. The claim (to quote the claimant's opening) is framed purely in contract based on the implied term of trust and confidence and in respect of contractually enforceable procedures that govern her contract of employment either as free standing rights, or in combination with the implied term. But in comparison (it seems to me) with the way the case was put in closing submissions, the breach of contract is relevant because it founds the claim for an injunction (there is no claim for damages because the claimant has been paid during her exclusion). The analysis of breach of contract has to been seen in the light of the relief sought. I do not consider that a declaration as to breaches of contract arises beyond that.
166. Mr Simon Gorton QC, counsel for the claimant, recognised in his oral closing, that there were difficulties in linking the breaches of the express terms relied on by reference to the *exclusion* procedure to the injunction which is sought restraining the holding of the ill health panel. He was right to do so, in my view, because the issues are distinct. If there are legitimate complaints in respect of breaches of the exclusion procedure, it does not follow that the defendant is in breach of contract in seeking to convene an ill health panel, which is what this case is about. Mr Gorton did however maintain that there are some breaches, eg, if a meeting was required which did not take place, that would go to the injunction issue, and relies on these matters in the context of his case as to the implied term of trust and confidence.

***The contractual basis for the convening of an ill health panel***

167. The constitution and procedure of the panel was dealt with in Dr Y's letter of 25 November 2009 which I have dealt with above. Whilst the proposal is there set out, there is force in my view in the criticism made by the claimant of the adequacy of the explanation provided by the defendant as to the contractual basis for convening an ill health panel.

168. The Policy and the MHPS envisage panels relating to capability, and conduct. Mr Giles Powell, counsel for the defendant, made it clear however that the ill health panel would follow the procedures for dealing with issues of capability. Support is found in Part IV of the MHPS, specifically at paragraph 10, which recognises that capability may be affected by ill health. Arrangements for handling concerns about a practitioner's health are described at Part V, which does not mention a panel, except by reference to disciplinary procedures. However paragraph 10 also states that employers must follow their own procedures for dealing with ill health. In the policy, handling health issues is dealt with in the context of capability.
169. Mr Gorton QC for the claimant submitted that the scheme of MHPS, when taken with the NHS material including that relating to Dr Leyton (the hypothetical paediatrician with bipolar disorder), and the Policy shows that ill health matters should if possible be dealt with by mutual agreement, avoiding the formality of a panel hearing. It seems to me that this is clearly correct, but equally, it does not follow that a panel may not be an appropriate procedure in particular cases. In the event, Mr Gorton conceded (in my view correctly) that the mere holding of an ill health panel is not a breach of contract. That was a significant concession.

***The claimant's case as to the breach of the exclusion procedures***

170. As stated, the claimant asserts that there has been a series of breaches of the exclusion procedures. Above, I have tried to fit this part of the claim into the overall claim. The defendant accepts that there have been breaches of the procedures. Its main point is that these procedures are not all apt for incorporation as contractual terms. The defendant criticises the claimant on the basis that there has been a lack of clarity as to which terms are relied on, whilst the claimant criticises the defendant for failing to engage with the substance of the particular complaints she makes. There is force in both criticisms in my view.
171. I deal first with the principles as to incorporation of provisions such as the MHPS and the Policy into an individual doctor's contract of employment. These were not substantially in dispute. The MHPS and the Policy adopted by the Trust to give effect to it are in essence collective agreements negotiated at the national level. It is accepted by the defendant that the Policy is incorporated into the claimant's contract of employment. It is therefore a term of the contract of employment that these procedures will be followed unless and until withdrawn by agreement (*Bristol City Council v Deadman* [2007] IRLR 888 at [17], Moore-Bick LJ). However this does not mean that every part of the policy is apt to be treated as a term of the contract (*Alexander v Standard Telephones & Cables Ltd* (No 2) [1991] IRLR 286, 292-3, Hobhouse J). The kind of factors that are relevant as regards the contractual status of particular provisions were recently considered in *Hussain v Surrey and Sussex Healthcare NHS Trust* [2011] EWHC 1670 (QB), particularly at [168], by Andrew Smith J. As well as paying regard to the words used, account has to be taken of the importance of the provision to employer and employee, the level of detail prescribed (since the court should not get involved in the micro-management of procedures), the certainty of the provision (a vague or discursive provision is less apt to have contractual status), the context, and whether the provision would be workable if given contractual status. As to the last point, the parties are not to be taken to have intended to introduce into their contracts of employment provisions which, if enforced, would

be unworkable, or would not make business sense (*Malone v British Airways plc* [2011] ICR 125, CA, at [62], Smith LJ).

172. In the first instance, the claimant relied upon paragraph 2.5 of the Policy (handling concerns about a practitioner's health) and paragraph 3.6 (handling health issues). The first, as I think Mr Gorton QC accepted, is at too high a level to be contractual. The second, is more specific, and may well be contractual in my view. However, the sub-paragraphs broadly appear to have been followed.
173. By contrast, the provisions as to *exclusion* set out specific procedures of a kind which (in principle) do fall within the criteria for contractual status. Not all the provisions do of course (see the above discussion as to *Hussain v Surrey and Sussex Healthcare NHS Trust*), but (in principle) the exclusion of a doctor from his or her place of work is such a significant step that it is reasonable to conclude that the parties must have intended that, as a matter of contract, the substance of the agreed procedure would be followed. This is set out at some length in paragraph 3.2, 3.3 and 3.4 of the Policy. In the context of this case however, and the relief sought by the claimant, I refer again to what Mr Gorton QC recognised in his oral closing, namely that there are difficulties in linking the breaches of the express terms relied on by the claimant by reference to the exclusion procedure to the injunction which is sought restraining the holding of the ill health panel. Without such a link, the breaches do not necessarily connect to the relief claimed in these proceedings.
174. As regards the specific points raised, my conclusions are as follows.
175. Immediate Exclusion: The claimant submits that Dr Y transgressed all of the defendant's obligations in respect of an immediate exclusion (paragraph 3.2.7) of the Policy. I reject this submission. Paragraph 3.2.7(a) was plainly satisfied on 30 March 2009. Matters had reached a critical stage, and there had been a total breakdown in relationships. I am quite satisfied that Dr Y had no realistic option but to exclude the claimant on that day, and it is unrealistic that this point should be in dispute.
176. Formal Exclusion: Paragraph 3.2.8 provides that a formal exclusion may only take place after the case manager has first considered whether there is a case to answer and then considered, at a case conference, whether there is a reasonable and proper cause to exclude. NCAS will be consulted where formal exclusion is being considered.
177. As is pointed out on behalf of the claimant, no clear distinction was drawn in this case between formal exclusion (as provided in paragraph 3.2.8) and immediate exclusion. Inevitably, Mr Gorton QC conceded that there was a *reasonable and proper cause* to exclude. It is correct that NCAS was not contacted for advice until 29 April 2009, but I do not consider this to be a breach in the circumstances.
178. Review process every four weeks prospectively: The relevant provisions are paragraphs 3.2.8(f) and (g), and 3.3.2(a) and (b). There were in fact, many reviews, albeit they were missed for a few months in 2011. I agree with the claimant however that the review process should have been prospective rather than retrospective. I also agree that proper regard was not paid to the provisions as to duration that are set out in these paragraphs. An exclusion is to last for four weeks at a time, and there are particular formalities to be observed after three exclusions. Although there is no bar to exclusions for over six months, that normally should be a maximum limit.

179. I agree with the claimant that these are important provisions, because—however difficult a case may be, and this one certainly was—delays in resolution are apt to leave the excluded doctor in limbo, which is unfair and undesirable. As a matter of fact, it is right to say that when the chronology in this case is examined fairly, there has been no *deliberate* delay by the Trust in this case. For example, considerable periods have elapsed whilst the parties’ legal advisers disagreed as to the way forward. Notwithstanding, in my view this breach is made out.
180. Board Consideration: if this is a contractual term (which I doubt), I accept the evidence of Ms HRT that the matter was placed before the board so far as possible, and in a reasonable way.
181. SHA: I accept Ms HRT’s evidence that proper returns were made to the Strategic Health Authority, which it required for statistical purposes. But there was no report as required when the exclusion extended over six months. Though there should have been, on balance, I do not consider that this provision was contractual. It concerned different relationships, namely those between the Trust and the SHA
182. Designated Board Member: if this is a contractual term (which I doubt), I accept Ms HRT’s evidence that a member was properly designated in this regard.
183. Exclusion Terms: I agree with the claimant that the relaxations put in place by Dr K could and should have been implemented earlier.
184. NCAS: the claimant says that NCAS, which ought to be pivotal, was kept at arm’s length, and was not “called in at all”. Based on my findings set out above, I accept that more use could have been made of NCAS than was made, but do not consider that it was not “called in at all”, or that this amounted to a breach of contract. In substance, my view is that the defendant appropriately involved NCAS, and so far as NCAS gave advice, or made recommendations, the defendant observed them.

***The claimant’s case as to the breach of the implied term as to trust and confidence***

185. There is no dispute as to the principle. As stated in the most recent authority, “it is now well established that an employment contract is subject to an implied term that the employer and employee may not without reasonable and proper cause, conduct themselves in a manner likely to destroy or seriously damage the relationship of confidence and trust between them (*Edwards v Chesterfield Royal Hospital NHS Trust* [2012] 2 WLR 55 at [1], Lord Dyson JSC, citing *Mahmud v Bank of Credit and Commerce International SA* [1998] AC 20). The matter is looked at objectively (*Malik v Bank of Credit and Commerce International SA* [1998] AC 20 at p.35C, Lord Nicholls), and a breach may be found in a cumulative series of acts or incidents (*Omilaju v Waltham Forest London Borough Council* [2005] ICR 481, Dyson LJ). On the other hand, as Hale LJ put it in *Gogay v Hertfordshire County Council* [2000] IRLR 703 at [55], “The test is a severe one. The conduct must be such as to destroy or seriously damage the relationship”.
186. The claimant submits that there is no reason in principle why this doctrine cannot be used to assess the defendant’s conduct culminating in the decision of Dr Y and Dr K to refer the matter to a panel. Although it is accepted that the statutory regime as to disability now in the Equality Act 2010 is not incorporated into the contract of

employment, the implied term of trust and confidence is apt, it is submitted, to oblige the defendant to take steps analogous to the duty to make reasonable adjustments i.e. take all reasonable steps to assist and facilitate claimant's return to work.

187. In the light of the authorities culminating in *Edwards v Chesterfield Royal Hospital*, I have some doubts as to whether this is a correct view of the law. However if correct, the proposition must be made good on the facts, bearing in mind that; "The test is a severe one. The conduct must be such as to destroy or seriously damage the relationship".
188. I have set out about the claimant's factual case in this respect. The facts alleged are (in essence) that the defendant deliberately failed to take reasonable steps to return the claimant to work, that Dr Y and Dr O in particular were determined to prevent this, that the joint instructing of Dr Reveley was "insincere" on behalf of the defendant, and that once her opinion was received the defendant set about misinterpreting it and finding ways to maintain its view that under no circumstances should the claimant return to work.
189. As is clear from the findings of fact set out above, I reject the claimant's factual case in this regard. Whilst criticism can be made of the defendant's conduct of this matter, the sincerity of the doctors charged with a series of difficult decisions is not in my view in doubt.
190. In closing, Mr Gorton QC put the case more persuasively. His principal point was that having agreed to the joint instruction of Dr Reveley, it was incumbent on the defendant to take reasonable steps to implement her recommendations. Essentially, Dr Reveley envisaged that a return to work by the claimant was possible, albeit subject to relatively stringent conditions. Rather than seek to explore how this might be achieved, he submitted, the defendant effectively reiterated its earlier decision. This, it is submitted, amounts to a breach of the implied duty of trust and confidence.
191. I have noted already that Dr Reveley's report is careful and nuanced. I add this comment. It is understandable that the claimant should not have wished the very personal matters described in the report to be passed to her colleagues. On the other hand, the result is that they have not had a chance to see her conclusions as a whole. For example, the fact that Dr Reveley addresses the early history of the claimant's condition, which is particularly sensitive so far as she is concerned, and measures the answers given by the claimant to her questions against the known facts without in any way minimising her lack of insight, tends to lend weight to Dr Reveley's overall conclusion that the claimant could return to work.
192. This is not an easy question, and I appreciate the force in Mr Gorton's submission. I approach the matter in this way. It is not for the court on this claim to determine whether Dr Y was right in his assessment. Ultimately, the decision he took in August 2011 (supported by NCAS) was to refer the matter to an ill health panel. For reasons I have explained, I consider that he was entitled (as case manager) to take a view as to the outcome, and express it. His views of course were conditioned by his first hand experience, and that of occupational health, and so far as August 2011 is concerned, the input he had received from the other consultants in the paediatric department, particularly the Clinical Director. Whilst criticisms can be made of his interpretation of Dr Reveley's recommendations, that is to say as to the concepts of supervision and

monitoring, and what I consider was a failure to engage properly with the claimant (whatever the practical difficulties may have been in that regard) in mid 2011, I have come to the firm conclusion that Dr Y's decision to refer the matter to the ill health panel cannot in any way be characterised as a breach of the implied duty of trust and confidence. It is a decision with which the claimant profoundly disagrees, and a different view could clearly have been taken. But it does not appear to me to be possible to say that it was not a decision which was open to Dr Y, or that he was otherwise than conscientious in reaching it. I do not accept the claimant's case in this regard.

***Should an injunction be granted?***

193. As I have said, it was accepted in argument on behalf of the claimant that the mere holding of an ill health panel would not be in breach of contract. Given my conclusions as to breach of contract, it follows that the claimant has not made out grounds for the grant of an injunction or declaration to the same effect. However, since the contractual position is not straightforward in this case, I should state my conclusions as to the grant of an injunction *in principle* on these facts.
194. In *Johnson v Unisys Ltd* [2003] 1 AC 518, it was held that the *implied* term of trust and confidence cannot be extended to allow an employee to recover damages for loss arising from the manner of his dismissal. In *Edwards v Chesterfield Royal Hospital* (ibid) it was held by the majority that damages are not recoverable for breach of contract in relation to the manner of a dismissal even where the breach was of an *express* term of the contract of employment regulating the disciplinary procedures leading to dismissal. However for present purposes, it is important to note that Lord Dyson (with whom Lord Walker agreed) said at [44], "That is not to say that an employer who starts a disciplinary process in breach of the express terms of the contract of employment is not acting in breach of contract. He plainly is. If that happens, it is open to the employee to seek an injunction to stop the process and/or to seek an appropriate declaration."
195. An example is to be found in *Mezey v South West London & St George's Mental Health NHS Trust* [2010] EWCA Civ 293. The background to the grant of an injunction by Underhill J, whose decision was upheld by the Court of Appeal, is that following an enquiry chaired by Mr Robert Francis QC, Dr Mezey had resumed her full range of duty from her clinical work to her teaching position and there was no suggestion from the Trust that that should change or that she should be dismissed whatever the outcome of any disciplinary proceedings: see the judgment of Ward LJ at [14]. It was held that the threshold for invoking any disciplinary procedure had not been crossed.
196. The present case is very different. The object of these proceedings is to prevent the defendant from convening a panel to *consider* the issues arising from the claimant's ill health. The proceedings come at an earlier stage than those in *Mezey*. An injunction is ultimately a discretionary remedy, and there are a number of reasons why I would not have felt able to grant it in this case, even if I had otherwise agreed with the claimant's analysis.

197. Mr Gorton QC submitted that, given the views expressed in the August 2011 management report, the result of a hearing would be a foregone conclusion. What, he asked, would be the purpose of such a hearing?
198. This would be a powerful point, if factually correct. However, the Trust has made clear that the hearing will take place by analogy with its disciplinary procedure in terms of the relevant personnel. That will require the panel to approach its task both fairly and independently. The panel must be properly constituted. The indications to date are that it will include an external Consultant Paediatrician. He or she can take an independent view as to whether the steps proposed by Dr Reveley are practical ones, which is the main issue between the parties.
199. Furthermore, it appears to me that Dr K's decision of 3 February 2012 becomes relevant in this context. I do not accept the defendant's submission that this decision can be seen as an answer to the objections the claimant has raised to the previous steps taken by Dr Y. In my view, it has to be seen not as a freestanding decision which changes the nature of the case, but as a further and final step in the existing process. However, the letter of 3 February 2012 does make clear what the earlier decisions do not explicitly make clear. Dr K spells out that it will be for the ill health panel "to consider all of the evidence and to decide whether or not you (i) remain in post with adjustments, (ii) are returned to a different role or (iii) your employment is terminated."
200. Those are in fact the available options, and whatever views may have been expressed in the past, it will be for the panel to take a fresh and independent look, and decide which one is to prevail.
201. A further issue that Mr Powell raises is as follows. Suppose the court was to grant this injunction, what would then ensue? The claimant (rightly) has not sought at any stage of these proceedings to suggest that the court should make an order permitting or requiring the Trust to allow her to return to work.
202. The answer given on her behalf was as follows. The defendant would have to look at the situation again, in the light of the judgment, and see where it had gone wrong. There is a wealth of material, it is submitted, as to how matters could move forward, and appropriate meetings could take place.
203. I can readily see the value of looking at the matter again, and that is what the ill health panel will be tasked to do. But the reality is that the result of granting an injunction would be to leave the parties where they already are, leaving them to continue their so far fruitless efforts to resolve the impasse by agreement, whilst preventing the Trust from convening a panel at which a decision which needs to be made can finally be taken. I do not consider that this is a course which the court should readily take.

### Conclusion

204. For all the above reasons, these proceedings must be dismissed. It was indicated to me at the hearing that whatever the outcome, it was likely that the parties would wish to discuss further steps in the light of the judgment. I am grateful to both of them for their assistance, and will hear them if necessary as to what further orders it is appropriate for the court to make.

