Neutral Citation Number: [2014] EWHC 756 (QB)

Case No: HQ13X05615

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 18/03/2014

Before:

His Honour Judge Birtles
(Sitting as a Deputy Judge of the High Court)

Between:

MICHELLE FYNES	**Claimant**
- and -	
ST GEORGE'S HOSPITAL NHS TRUST	**Defendant**

Mr Jeremy Hyam (instructed by **Eastwoods Solicitors**) for the **Claimant**
Mr Mark Sutton QC and Miss Louise Chudleigh (instructed by **Capsticks Solicitors LLP**) for the **Defendant**

Hearing dates: 30, 31 January 2014

Approved Judgment

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

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HIS HONOUR JUDGE BIRTLES

His Honour Judge Birtles :

Introduction

1. By this application/claim, the Claimant, a Consultant in Urogynaecology employed by the Defendant seeks

   (i) injunctive relief and/or declaratory relief that the Defendant has acted in breach of the express term of the Secretary of State for Health's guidance contained in Maintaining High Professional Standards in the Modern NHS ("MHPS") and/or an implied term of trust and confidence in her contract of employment which incorporates the provisions of MHPS;

   (ii) (without prejudice to the contention that damages are not an adequate remedy) damages or such other relief as the Court thinks just.

2. The Claimant is represented by Mr Jeremy Hyam of counsel. The Defendant is represented by Mr Mark Sutton QC and Miss Louise Chudleigh. I am grateful to all counsel for their written and oral submissions.

3. The hearing took place on 30-31 January 2014. At the conclusion of the hearing I reserved judgment.

The Pleadings

4. The Particulars of Claim set out the key facts relied upon by the Claimant which are that the Claimant is a Consultant Urogynaecologist at the Defendant Trust having been appointed to that post in September 2003. At times, and particularly during 2011 and 2012 the Claimant suffered from a severe depressive illness for which she sought help including from the Defendant's Occupational Health Physician, a Doctor Thayalan, who advised her to seek urgent psychiatric help which she did at the Priory Hospital in Roehampton.

5. Between 21 December 2011 and 17 May 2012 the Claimant was involved in a number of work related incidents which now form six specific allegations of misconduct. She was invited to a disciplinary hearing on 21 November 2013 to consider those allegations.

6. The Claimant's case is that:

   (i) Each of the allegations has wrongly been classified as a conduct allegation under the Defendant's Disciplinary Policy and MHPS, as opposed to

      a) health matters, or alternatively should have been classified as

      b) mixed professional capability and health allegations.

   Mr Hyam also submits that even if the classification was in the alternative, a mix of conduct, capability and health (see paragraphs 9-10 of the Particulars of Claim) this

would in any event require a capability hearing and the procedural protections guaranteed thereby in MHPS.

(ii) By reason of such wrongful classification, the procedure that has been followed to date, and that arranged for the hearing on 21 November 2013, is procedurally inappropriate and in breach of contract, and the Claimant is entitled to an injunction to prevent the hearing going ahead.

7. With the agreement of the parties the hearing on 21 November 2013 was adjourned until after the conclusion of these proceedings.

8. The Defence sets out the Defendant's policy in a document called "Medical and Dental Staff Conduct and Capability Policy and Procedure" ("the Medical Staff Procedure"). It also sets out the Defendant's view of the important factual background.

9. The Defence denies that any of the allegations relate to health and/or capability as alleged in the Particulars of Claim and denies that the allegations have been wrongly classified. The Defence goes on to deny that there has been any breach of the Claimant's contract or that the conduct is discriminatory.

10. There is no Reply.

The Evidence

a. Documentary Evidence

11. I read and was referred to a trial bundle consisting of 2 lever arch files.

b. Oral Evidence

12. I heard no oral evidence but I read the witness statements of (a) Michelle Maria Fynes who is the Claimant and (b) Dr Rosalind Given-Wilson who is the Medical Director at the Defendant Trust.

The Factual Background

13. The Claimant is a Consultant Urogynaecologist at the Defendant Trust. She was appointed to that post on 1 September 2003 and is employed pursuant to a letter of appointment dated 25 September 2003: TB1/6/1-3.

14. The Claimant had qualified as a doctor in 1991, obtained membership of the Royal College of Obstetricians and Gynaecologists in 1996 and underwent her sub-speciality training in urogynaecology at St George's Hospital prior to her accreditation in 2003.

15. In 2003 and 2005 the Secretary of State for Health issued Directions which required NHS bodies, including the Defendant, to implement into its local procedures the guidance contained in MHPS.

16. In conformity with those Directions, the Defendant introduced procedures modelled on the MHPS framework in a policy which in its short form I shall refer to as "the

Medical Staff Procedure": TB4/60-100. The relevant version of this procedure was ratified on 28 April 2011.

17. The Medical Staff Procedure is intended to address "serious concerns about a practitioner's conduct or capability". The determination of whether a serious concern has arisen is one for the Medical Director to take in consultation with Human Resources staff: see Part 1 Introduction: TB4/64. The Defendant's Medical Director, at all relevant times, was Dr Rosalind Given-Wilson. Dr Given-Wilson, throughout the material period has discharged the role of Case Manager under the Medical Staff Procedure: Part 1 paragraph 5.2: TB4/66.

18. The Medical Staff Procedure makes clear that misconduct matters involving medical practitioners are for the Defendant to resolve locally under its disciplinary procedure, following an investigation. Conduct matters concerning practitioners are dealt with under the disciplinary procedure applicable to Trust staff generally: Part 1 paragraph 3.1: TB4/65.

19. Examples of concerns falling under the heading of "Conduct" are provided in Part 1 paragraph 3.1 of Medical Staff Procedure: TB4/65. These include:

> " • A refusal to comply with the reasonable requirements of the Trust;
>
> • An infringement of the Trust's Disciplinary Rules, including standards of professional behaviour required by the relevant regulatory body;
>
> • Wilful, careless, inappropriate or unethical behaviour likely to compromise standards of patient care or safety.
>
> • Failing to provide proper support to other members of staff".

20. Capability concerns are discussed at Part 1 paragraph 3.2 of the Medical Staff Procedure: TB4/65. Concerns under this heading include behavioural difficulties or lack of clinical competence or where failures to deliver adequate care stem from a "lack of knowledge, ability or consistently poor performance".

21. In contrast with conduct concerns, where the applicable formal procedures are contained in the Defendant's disciplinary procedure, the Medical Staff Procedure sets out detailed provisions in relation to the management of capability concerns. Where such concerns cannot be managed informally, it is stipulated that the National Clinical Assessment Authority ("NCAS") must be contacted for support and guidance before the matter can be referred to a capability panel: Part 2 paragraph 1: TB/4/78.

22. A capability hearing will normally be chaired by an Executive Director of the Defendant Trust, advised by a senior member of staff from the Human Resources Department and a senior clinician from another NHS Trust: Part 2 paragraph 3.3: TB/4/79. The practitioner may be accompanied at the hearing. Both parties have the opportunity to call witnesses: Part 2 paragraph 4: TB/4/80. A range of sanctions is available to the capability panel, up to and including termination of employment: Part

2 paragraph 5: TB/4/80-81. Provision is made for a right of appeal, with detailed procedures governing the appeal process.

23. Where there is an overlap between conduct and capability concerns, the Medical Staff Procedure states that usually both matters will be heard under the capability procedure: Part 2 paragraph 1: TB/4/78. In exceptional circumstances, it may be "necessary" for issues to be considered under separate procedures. "Necessary" in this connection means "what would be appropriate in the circumstances" rather than applying a test of strict necessity. It is a matter for the discretion of the Case Manager: West London Mental Health Trust v Chhabra [2013] UKSC80 at paragraph 41 per Lord Hodge JSC.

24. Part 3 of the Medical Staff Procedure provides for various scenarios where a practitioner's performance (whether conduct or capability) is affected by ill health. Where (as here) concerns arise about a practitioner's conduct or capability in circumstances where a practitioner has experienced ill health, the Case Manager must decide whether the issues of concern have arisen "solely as a result of ill health on the part of the practitioner": Part 3 paragraph 1: TB/4/85. This decision is to be taken on the basis of a report from Occupational Health: Part 3 paragraph 3: TB/4/86. In the event that ill health is considered to be the sole cause of the concern, the Case Manager has a range of options, including management of the case under the Defendant's Sickness Absence Procedure: Part 3 paragraph 4: TB/4/87.

25. NCAS provides an advisory facility under the MHPS frameworks. NCAS is an external and independent body with responsibility for providing guidance to NHS Trusts (and practitioners) on how to respond to concerns affecting performance, whether relating to conduct, capability and/or health. NCAS is consulted about the applicable procedures and, in appropriate cases, is able to undertake performance assessments in order to determine a practitioner's clinical competence. Their role is expressed in the Medical Staff Procedure at Part 1 paragraph 5.4: TB/4/66.

26. The Case Investigator's duties are explained in the Medical Staff Procedure at Part 1 paragraph 6.1: TB/4/68. The Case Investigator's report is required to provide the Case Manager with sufficient information to decide on which of a range of the procedural routes to adopt: Part 1 paragraph 6.4 and 12: TB/4/69 and 76. These include taking the concerns forward to a conduct hearing; exploring the matter further with NCAS; and proceeding to a capability panel.

The Allegations

27. Concerns were raised in December 2011 and January 2012 about the Claimant's conduct. Specifically, it was reported that on 21 December 2011 the Claimant had improperly attempted to expedite NHS surgery for a patient seen by her in private practice contrary to the Department of Health's Code of Conduct for Private Practice (allegation number 1) and that she had neglected to consent the same patient for surgery as the patient's responsible lead consultant (allegation number 2).

28. As a result of these concerns, Dr Given-Wilson, the Defendant's Medical Director was appointed as Case Manager under the terms of the Medical Staff Procedure. She in turn appointed Dr Jeremy Cashman, Associate Medical Director, to undertake an investigation into the concerns surrounding the treatment of that patient.

29. Dr Cashman conducted an investigation in the course of which he interviewed the Claimant and gathered evidence from a number of further witnesses. The Claimant submitted a written statement dated 7 February 2012, headed "Draft Letter for Investigation": Cashman report appendix 11: TB7/7/87. In this document the Claimant sets out detailed and closely argued refutation and a Defence. The written submission was accompanied by a number of appendices. The Claimant made no reference to her own health as a material factor.

30. On 20 February 2012 the Claimant attended an interview with Dr Cashman, accompanied by her BMA Representative: Cashman Report: appendix 13: TB/7/135-148. The Claimant provided a detailed response to the criticisms of her conduct in relation to that patient. She identified witnesses who she said were with her at key points in the patient's treatment and who would be in a position to corroborate her account of events. Again, at no point in the interview did the Claimant make any reference to her own health as having played any part in the manner in which she conducted herself. The day following the meeting, the Claimant indicated her wish to amend the notes of the meeting in order to "give absolute clarity": Cashman Report: appendix 3: TB/7/50.

31. Dr Cashman's Report was produced in March 2012: TB/7/1-271. Following consideration of that report, Dr Given-Wilson concluded that there was a case of misconduct that should be considered under the Defendant's disciplinary procedure. The Claimant was informed of this in a letter dated 11 May 2012: TB/5/31.

32. Further allegations arose. On 12 April 2012 the Claimant was the on-call Consultant/lead Urogynaecologist when advice was sought from her late at night about a patient who had been admitted as an emergency and diagnosed with an ectopic pregnancy. Serious concerns were raised regarding the Claimant's conduct in relation to this patient including:

    (i) Failure to respond to several attempts to telephone her on her mobile telephone and home telephone:

    (ii) Failure to attend the Hospital and perform an emergency laparoscopy, despite the fact that the patient had fainted and there were changes in her vital parameters which would have made it obvious to the Claimant that immediate surgery was essential, resulting in delay in treatment;

    (iii) The prescription of Zopiclone for this patient, a hypnotic drug that may mask symptoms of deterioration and which the Claimant would have known was an inappropriate and potentially dangerous drug for her to take.

33. Allegation 3 relates to (i) above and allegation 4 relates to (ii) and (iii) above.

34. On 26 April 2012 Parkside Hospital suspended the Claimant's practising privileges after concerns had arisen there about the standard of patient care and the Claimant's behaviour: TB/7/384. After their own internal investigation, Parkside Hospital referred various matters to the General Medical Council ("GMC"). This referral in due course triggered a GMC performance assessment.

35. On being notified of the Claimant's suspension by Parkside Hospital, the Lister Hospital also took the decision to suspend the Claimant's practising privileges. It notified the Defendant Trust of this on 27 April 2012 and said that it had concerns surrounding the Claimant's decision to transfer 2 of her patients from Parkside Hospital to the Lister Hospital late on the evening of 26 April 2012 following her suspension. It also alleged that the Claimant had attempted to transfer private patients to St Anthony's Hospital and that at the time of the attempted transfers she did not inform either Hospital of her suspension by Parkside Hospital as she was obliged to do: TB/5/27. This is allegation number 5.

36. On 17 May 2012 an incident occurred when it was alleged that the Claimant failed to respond appropriately to a request from a junior colleague for support with emergency laparoscopic surgery when she was again the on-call Consultant. It is alleged that the Claimant was contacted on her mobile phone. She failed to attend and assist and, instead, sent another junior colleague. That colleague, who was insufficiently experienced, performed the surgery but the patient needed a second procedure as some residual ectopic material was left behind in the pedicle. This is allegation number 6.

37. In the light of these allegations, the Claimant was excluded from her NHS duties at a meeting on 22nd May 2012: TB/5/31A. Immediately prior to that meeting, the Claimant wrote an email to her Clinical Director, Mr Edwin Chandraharan on 20th May 2012 following up an earlier telephone call in relation to the 17th May 2012 incident. The Claimant explained that she had based her decision on the "information (she) was given at the time such that (she) arranged for a known and extremely competent Fellow to see the patient and operate": TB/7/345-346.

38. The Claimant went on to deny having missed any calls on her mobile telephone, but suggested that in the future she should carry an air call bleep for back-up "when there is any doubt about phone reception". When the Claimant made reference to attending an Occupational Health appointment during the relevant DCC session, she again did not ascribe her failure to attend as being associated with ill-health. Instead she maintained that she had acted quite appropriately in arranging a clinical Fellow, Dr Maya Basu, to attend to the emergency.

39. In his email to the Medical Director dated 21st May 2012, Mr Chandraharan pointed out that, in the course of their discussion the previous Friday, the Claimant had maintained that she was present in the urogynaecological clinic when she was requested to attend Accident and Emergency, and that she had sent her clinical Fellow to the theatre so that she could see "8 patients waiting in the urogynae clinic much quicker". Mr Chandraharan noted the different explanations offered in the Claimant's subsequent email: TB/7/345.

40. In the course of the meeting held on 22nd May 2012, at which the Claimant was excluded from her NHS duties, she was asked whether she required time on sick leave. She stated that this was not necessary and that she could swap her on-calls until later in the year as the problems seemed to be occurring when she was on-call. Her explanation that Dr Basu felt confident to undertake the procedure was contradicted by accounts given to the Medical Director by the Department: TB/5/31A.

41. Dr Given-Wilson appointed Ms Julia Hollywood of Hollywood Consulting Limited in June 2012 to enquire into these matters and provide a report. Ms Hollywood's investigation was delayed due to the Claimant's absence on sick leave, which she commenced in June 2012. The Claimant was not available to be interviewed until February 2013. The Claimant then declined to be interviewed but did provide a statement and a response to a questionnaire.

42. In her letter of 14th February to Ms Hollywood the Claimant explained that she had already supplied a minuted account of the events (in relation to the gynaecological emergency) to Dr Given-Wilson when she was suspended on 22nd May 2012. She claimed that, on medical advice, it would be deleterious to her mental health to provide any further account other than that referred to above. The Claimant went on to contend that she could not remember the events in detail and any attempt to answer questions would be "inappropriate": TB/7/469.

43. In relation to the concern that the Claimant had sought to transfer patients from Parkside Hospital to other private hospitals following the suspension of her practising privileges at that hospital, the Claimant offered a detailed explanation, in which she refuted any criticism on the basis that Parkside Hospital had failed to give "sufficient thought" to the on-going care of the patients and that she had been placed in an "untenable position". The Claimant went on to produce an "excerpt" from a letter she had sent to the Lister Hospital. The Claimant, whilst acknowledging that she "should have sought more advice earlier", did not attribute the criticised conduct to her health condition at the material time: TB/7/472.

44. Ms Hollywood's report is dated 21st April 2013: TB/286-468. Upon receipt of that report, Dr Given-Wilson held a meeting with the Claimant on 16th May 2013 and informed her that having considered both reports, she had concluded that there was a case to answer at a disciplinary hearing in relation to six separate matters: TB/5/40.

45. In March 2013 a team of four assessors was appointed by the GMC to conduct an assessment into the concerns about the Claimant's performance. The assessment involved peer review of at least 42 sets of medical records, interviews with the Claimant, third party interviews (nominated in part by the Claimant) and tests of competence, which included a knowledge test and simulated surgery. On 26th June 2013 the assessors reported that there was no evidence that the Claimant's professional performance had been deficient: TB/6/26-99.

46. In interview, the assessors asked the Claimant to comment upon her extremely busy work schedule, both with the NHS and in the private sector, and asked her how she balanced these commitments. The Claimant responded that she "recognised she had been working excessively which might have been a contributory factor in her current problems": Assessors' Report paragraphs 1.38-1.39: TB/6/40. The assessors commended the Claimant on submitting an "extremely detailed and well organised portfolio": Assessors' Report paragraph 2.4: TB6/43.

47. The Claimant explained to the Assessors the correct management plan for patients with ectopic pregnancy, identifying the risks and the benefits associated with medical and surgical management of such cases: Assessors' Report page 60 Station 7: TB/6/85. The Claimant was able to demonstrate, through case based discussion, that

she was familiar with the importance of giving clear information to patients and involving them in decision making: Assessors' Report paragraph 4.4.11: TB/6/80.

48. The Assessors' Report records the Claimant as having ascribed the problems she encountered at work to various factors: first, "severe depressive illness": Report paragraph 6.5; second, working too hard: Report paragraph 6.6; and third, relationship difficulties with a colleague, Mr Doumouchstis: Report paragraph 6.7. One of the Claimant's nominated interviewees, Mr Tom Ind, a Consultant Gynaecological Oncologist, considered that the relationship difficulties between the Claimant and Mr Doumouchstis, characterised by him as a "catastrophic falling out", were at the root of the Claimant's problems: Assessors' Report paragraph 4.5.21: TB/6/92.

49. A disciplinary panel was appointed and its chairman, Mr Andrew Fleming, a Consultant Surgeon and Divisional Chair, wrote to the Claimant on 27th June 2013 inviting her to a disciplinary hearing on 11th July 2013: TB/5/43-44. That hearing was subsequently postponed at the request of the Claimant.

50. On 6th August 2013 the Claimant's Medico-Legal Adviser, Dr Judith Clark, wrote to Mr Fleming contending that the six disciplinary allegations all occurred at a time when the Claimant was unwell: TB/5/45-46. She enclosed the report by Dr Max Henderson dated 25th July 2013. Dr Clark invited Mr Fleming to consider whether a formal disciplinary hearing was appropriate.

51. In response, the Defendant reviewed the report of Dr Henderson and requested Dr Thayalan, Consultant Occupational Health Physician and Head of the Defendant's Occupational Health Department, to consider Dr Henderson's report, together with the medical reports produced for the GMC assessment by Professor Tom Sensky dated 31st October 2012: TB/3/1-11 and Dr Charlotte Feinmann dated 2nd November 2012.

52. Dr Thayalan had seen the Claimant regularly since 2008. He had assessed her on a number of occasions: 12th and 31st January 2012; 23rd and 28th February 2012; 1st, 10th, 18th and 25th May 2012; and 1st and 12th June 2012.

53. Dr Thayalan produced a report dated 4th September 2013, having reviewed the five reports submitted by Dr Thompson, who was treating the Claimant during the material period at the Priory Hospital, together with the further reports produced by the GMC's psychiatric assessors, Professor Sensky and Dr Feinmann. Dr Thayalan also reviewed Dr Henderson's report dated 25th July 2013. Dr Thayalan produced a further report dated 7th December 2013, specifically addressing the impact of the Claimant's health on the disciplinary allegations: TB/1/60.

54. Dr Thayalan's opinion was that the Claimant had a mixture of anxiety and depressive symptoms during the material period, but she was well enough to be at work and would have had the mental capacity to understand the nature of interaction with her colleagues and managers, although her emotional responses would have been affected by her health. He specifically advised that "the issues under investigation could not have arisen solely as a result of Dr Fynes' ill health": TB/1/60.

55. Dr Henderson's opinion was that at the material time the Claimant was suffering from a major depressive illness that "had a significant impact on her behaviour,

interpersonal/professional communication skills and clinical performance …": Report 25th July 2013 paragraph 47: TB/3/27. He does not maintain that her criticised conduct was caused solely by ill health and, specifically, does not say that the six incidents in question occurred because of the Claimant's depressive illness.

56. Dr Henderson wrote a further report dated 9th January 2014: TB/3/30-39. That was not part of the material considered by the Case Manager for consideration because it postdates that decision. However, it takes matter no further. In response to a question from the Claimant's solicitors as to whether he considered it likely that the Claimant's condition caused or materially contributed to impairment of clinical judgment and decision making, Dr Henderson is unable to say that the behaviour in question was caused solely by the ill health. He does not comment on the six specific allegations.

57. In her witness statement, Dr Given-Wilson explains why she determined that it was appropriate to proceed to a disciplinary hearing in the light of the medical reports and the advice of Dr Thayalan: witness statement paragraphs 42-47 and 49: TB/2/75-76.

58. Having recited the medical evidence which I have just referred to, she says this at paragraphs 46 and 49:

> "46. In the circumstances, I am satisfied that the concerns did not arise from a lack of clinical competence or capability. The behaviours outlined in the allegations are properly categorised as wilful, careless, inappropriate and unethical, to the extent that they were likely to compromise standards of patient care and patient safety. I am satisfied that the concerns did not arise solely as a result of Dr Fynes' ill health.
>
> …
>
> 49. The issues in question are matters of serious concern which could have compromised standards of patient care and patient safety. I believe that it is important that they be explored at a disciplinary hearing as I am of the opinion that the evidence suggests potential misconduct on the part of Miss Fynes. The Trust is aware that Miss Fynes was suffering from ill-health at the material time. It has taken appropriate advice on whether the ill-health caused Miss Fynes to behave as alleged and having done so, considers that it is appropriate to proceed with the hearing as there is no evidence to suggest that the incidents occurred solely as a result of ill-health. Miss Fynes will have an opportunity at the hearing to advance her case as to the contribution of her health by way of Defence and /or mitigation": TB/2/76-77.

59. Mr Fleming wrote to Dr Clark on 18th September 2013 to say that the decision had been taken that it was appropriate to proceed to a formal disciplinary hearing on 21st November 2013. He indicated that the Claimant would be entitled to make any submissions she considered appropriate for the panel to consider: TB/5/49. As I have indicated, this hearing was postponed because of the Court proceedings.

60. Finally, I should mention that the Defendant Trust has granted permission to the Claimant to be represented by a lawyer at the hearing and she has been informed that an independent Consultant Psychiatrist (Dr Whicher) will be present on the disciplinary panel to provide appropriate advice as to the impact of the Claimant's ill health on her alleged conduct. It will be open to the Claimant to call her treating psychiatrist as a witness at the hearing, and to place before the disciplinary panel any other medical information relating to the allegations. Dr Thayalan will also be available to attend the hearing if required to explain the basis for his assessments detailed above. The Claimant's case is that these modifications to the disciplinary procedure are insufficient and that she should not be the subject of a disciplinary hearing at all.

The Issues

61. The parties have been able to agree a list of issues and I propose to take them in turn.

Issue 1: Is MHPS incorporated into the contract of employment such that its terms can be directly relied on by the Claimant?

62. Mr Hyam submits that the terms of MHPS were incorporated into the Claimant's contract of employment. He also submits that the Defendant's own Medical Staff Procedure was also incorporated into the Claimant's contract of employment.

63. Mr Sutton QC accepts that in responding to concerns about the Claimant's performance (be it related to conduct or capability), the Trust was contractually obliged to apply the provisions of its disciplinary policy and Medical Staff Procedure as appropriate. He does not accept that each of the provisions of those policies is apt to be given effect as a contract term. Many of them, he submits, are in the nature of guidance.

64. Both counsel agree with the approach of Andrew Smith J in Hussain v Surrey and Sussex Healthcare NHS Trust [2012] Med LR 163 at paragraph 168, where he analyses the relevant indicia where a provision is to be taken to have contractual status. At paragraph 174 Andrew Smith J rejected Dr Hussain's various other complaints that the procedures adopted for investigating and otherwise dealing with her case were not in accordance with the relevant disciplinary procedure. He did not consider that parts of the disciplinary procedure on which those complaints were based were contractual. He said this:

> "I cannot accept that the parties to individual contracts of employment intended that the detailed provisions about investigations ... and about other matters should be enforced through the legal process as breaches of contract, with the Court 'micro-managing' those arrangements. I consider that these paragraphs are to be understood by way of advice or guidance to investigators and others."

65. In Kerslake v North West London Hospitals NHS Trust [2002] Med LR 568 HHJ Curran QC sitting as a High Court Judge said this at paragraph 151:

> "Applying the principles explained in the authorities which are mentioned above to the circumstances of this case I have reached the following conclusions on the question of incorporation.
>
> (1) MPHS parts 1-4 are incorporated into the contract of employment insofar as they deal with concerns over conduct and capability.
>
> (2) The detailed terms of the Investigation Policy are essentially matters of guidance which require adaptation to the circumstances of any individual case. In that case they are not apt for incorporation into the contract. (Were they to be regarded as contractual, the Court might have to become involved in micro-management by an examination of their potential application line by line in the individual case.)
>
> (3) If that is not a correct conclusion, I would hold that, in any event on its proper construction the Investigation Policy applies only to work-related issues involving (a) the conduct or capability of individual employees and (b) complaints by such employees raised as grievances.
>
> (4) [Not relevant]
>
> (5) Whilst the involvement of NCAS is a necessary contractual step in a conduct and capability case before referral may be made to a capability panel, there is no other contractual requirement to follow any particular advice which NCAS gives."

66. Finally, I should refer to the *obiter* remarks by Lord Hodge in West London Mental Health NHS Trust v Chhabra [2013] EKSC 80 at paragraph 41, where he said this:

> "Secondly, the Trust had a discretion under paragraph 4.5 of policy D4A … whether to combine issues of capability and conduct in a capability hearing. The Trust's decision that it was appropriate to convene a conduct panel for the discrete complaints about Dr Chhabra's conduct was within its discretion. I construe the guidance in that paragraph, when it speaks of there being occasions when 'it is necessary to pursue a conduct issues separately', as referring to what is appropriate in the circumstances rather than a test of strict necessity. Such a test would not be consistent with the subsequent reference to the Trust deciding upon 'the most appropriate way forward'. It is not necessary for me to decide whether these clauses are apt for incorporation into the contract of employment or are mere guidance."

67. I disagree with HHJ Curran QC's conclusion at paragraph 151 of Kerslake supra at paragraph 151. In my judgment MHPS is not incorporated into the Claimant's contract of employment for the following reasons:

(i) MHPS is not referred to at all in the Claimant's contract of employment: TB/6/1-3.

(ii) In Hussain, supra, Andrew Smith J was not dealing with incorporation of MHPS into Dr Hussain's contract of employment but the Surrey Healthcare NHS Trust's own disciplinary or capability procedures. That is this case. The contract of employment states that:

"In matters of personal conduct you will be subject to the Disciplinary Procedure a copy of which is attached."

Issue 2: Is it an implied term in the contract of employment that the Defendant would comply with the terms of MHPS?

68. Mr Hyam submits in the alternative that even if MHPS is not incorporated as a term of the Claimant's contract of employment it will be an implied term that the Defendant will in fact follow it unless it can show good reason not to do so. This is necessary to give effect to the contract as a whole and it is an incident of the employer's implied duty of good faith. Mr Hyam refers me to Lim v Royal Wolverhampton Hospitals NHS Trust [2011] EWHC 2178 (Slade J); Lakshmi v Mid Cheshire Hospitals NHS Trust [2008] IRLR 956 and Hussain v Surrey and Sussex Healthcare NHS Trust [2012] MED LR163 to which I have already referred to. Mr Sutton QC did not really make any submissions on this issue because he accepts in paragraph 50 of his skeleton argument that the Defendant's disciplinary policy and Medical Staff Procedure are matters of contract as appropriate. However since the parties have agreed this as an issue I must deal with it.

69. The locus classicus on implied terms is the judgment of Lord Hoffman in Attorney General of Belize and others v Belize Telecom Limited and another [2009] 1 WLR 1988 at paragraph 16-27. See also Chitty on Contracts chapter 13 (31st edition 2012). These authorities were not cited to me in oral argument. However, the guidance given by Lord Hoffman in the Belize case, supra, is of great authority and I follow it. In my judgment there is no basis for finding that any part of MHPS or any part of it is an implied term of the Claimant's contract of employment. It is simply not necessary to do so because my finding under Issue 3 is that the Defendant's Medical Staff Procedure, or at least the relevant parts of it in this case, are incorporated into the Claimant's contract of employment. That document is at TB/4/6C-100. As I have already indicated, it is the document which the Defendant has put into place in order to comply with MHPS following the Secretary of State's directions in 2003 and 2005. As the Executive Summary makes clear it "applies to all grades of medical and dental staff (referred to as the "practitioners") employed by the Trust.": TB/4/63.

Issue 3: Are the provisions of the Defendant's Medical and Dental Staff Conduct and Capability Policy (the purpose of which is to implement MHPS in the local policy), or those

parts of it that are apt for incorporation into the contract of employment, terms of the contract?

70. My answer to this question is in the affirmative. I have already reviewed the relevant authorities in relation to incorporation under Issue 1 above. Applying the test as set out by Andrew Smith J in the Hussain case, supra, I find that parts at least of the Medical Staff Procedure are incorporated into the Claimant's contract of employment and in particular the relevant parts that are applicable to this particular case. It is not necessary in this case to decide about the incorporation of the remainder of Parts 1 of the Medical Staff Procedure. In addition I should note that the Trust's own Disciplinary Procedure: TB/4/101-120, is expressly incorporated into the Claimant's contract of employment: see the letter of appointment dated 25 September 2003 page 3: TB/6/3.

71. If I am wrong about that then I respectfully follow the approach taken by Lord Hodge JSC in the Chhabra case, supra, at paragraph 41.

Issue 4: Is the Defendant in breach of its contract with the Claimant by arranging a dismissal hearing for misconduct in respect of the 6 allegations listed in the Defendant's Management Statement of Case before a disciplinary panel by reason of the fact that the proper classification is not "conduct" but:-

(i) Health; (see paragraph 9 Particulars of Claim)

(ii) A mix of health and capability (see paragraph 9 Particulars of Claim) or alternatively

(iii) A mix of conduct, capability and health (see paragraphs 9 and 10 Particulars of Claim) which would in any event require a "capability" hearing and the procedural protections guarantee there by MHPS.

72. I first consider the relevant provisions of the Defendant's Medical Staff Procedure. Paragraph 3.1 says this:

> **"3.1 Conduct**
>
> Misconduct matters for medical practitioners, as for other staff groups, are matters
>
> for the Trust to resolve locally. All issues regarding the conduct of practitioners will
>
> be dealt with under the Trust's Disciplinary Procedure following an investigation.
>
> Examples of misconduct will vary widely by may fall into one of the following broad
>
> categories:

- A refusal to comply with reasonable requirements of the Trust.

- An infringement of the Trust's Disciplinary Rules including standards of professional behaviour required by the relevant regulatory body;

- Commission of criminal offences outside the workplace

- Wilful, careless, inappropriate or unethical behaviour likely to compromise standards of patient care or safety or likely to create serious dysfunction to the effective running of the service

- Failure to fulfil contractual obligations

- Failing to provide proper support to other members of staff."

73. Capability is dealt with in paragraph 3.2 which says this:

> **"3.2 Capability**
>
> Concerns about the capability of a practitioner may arise from a single incident or series of events, reports or poor clinical outcome. Capability matters may include behavioural difficulties or lack of clinical competence, and where the Trust considers that there has been a clear failure by a practitioner to deliver an adequate standard of care, or standard of management, through lack of knowledge, ability or consistently poor performance, these matters are described as capability issues. If the concerns cannot be resolved routinely by management the matter must be referred to the NCAS before the matter can be considered by capability panel. The following are examples of matters which the Trust may regard as being concerns of capability (this is not an exhaustive list):-
>
> - Out of date or incompetent clinical practice (unless this is contrary to clear management requests made previously in which case the issue may be one of misconduct – see paragraph 8) ;
>
> - Inappropriate clinical practice arising from a lack of knowledge or skills that puts patients at risk;
>
> - Inability to communicate effectively;
>
> - Inappropriate delegation of clinical responsibility;
>
> - Inadequate supervision of delegated clinical task;

- Ineffective clinical team working skills.

Capability may be affected by ill-health. Arrangements for handling concerns about a practitioner's health are described in Part 3 of this policy."

74. The procedure is set out in paragraph 6 and requires the involvement of the NCAS following the local investigation. At paragraph 45 of her witness statement Dr Given-Wilson states that she had also sought advice from NCAS throughout the process. I accept that evidence.

75. Part 2 of the Medical Staff Procedure deals with capability procedures. Paragraph 1 specifically deals with the question of an overlap. It says this:

> "In the event of an overlap between issues of conduct (see paragraph 8) and capability, then usually both matters will be heard under the capability procedure. In exceptional circumstances, it may be necessary for issues to be considered under separate procedures. The decision as to which procedure shall be initiated shall be taken by the Case Manager in consultation with the Director of Human Resources and Organisational Development and the NCAS."

76. Part 2 sets out in considerable detail the procedure to be followed in a capability case.

77. Part 3 of the Medical Staff Procedure is headed "Handling Concerns about A Practitioner's Health. Paragraph 1 says this:

> **"1 Introduction**
>
> This part applies to the following circumstances:
>
> - Where the practitioner is off sick and no concerns have arisen about conduct or capability;
> - Where the issues of capabilities or conduct are decided by the Case Manager to have arisen solely as a result of ill health on the part of the practitioner;
> - Where issues of ill health arise during the application of the procedures for addressing capability or conduct.
>
> Separate procedures are set out below in respect of each of these eventualities.
>
> This procedure should be read in conjunction with the Trust's "Sickness Absent Policy.""

78. This particular case falls under the third category. That is dealt with in section 4 in the following terms:

> "This section addresses circumstances where:

- Part way through a conduct or capability procedure the practitioner argues any concerns were caused by his/her ill health.

- Where the practitioner says a capability or conduct procedure should be delayed because of his/her ill health.

- Where a practitioner says conduct or capability procedures should be halted and purely handle the health issue."

79. This case falls into the first category. That is dealt with in paragraph 4.1 which says this:

> **"4.1 Practitioner arguing concerns are caused by ill health**
>
> In this situation the first step for the Case Manager is to obtain an Occupational Health Report as set out above. If there is a dispute as to whether or not the practitioner's ill health caused the concerns or Occupational Health has been unable to offer a view on this, then the Case Manager may refer the practitioner to a specialist for further opinion. If Occupational Health is clear, the Case Manger is entitled to act on the basis of this advice. He/she is also entitled to action the basis on the specialist's advice (if obtained) if that conflicts with the practitioner's medical advice. The Case Manager should seek advice from the NCAS on this issue. Where there is such dispute the Case Manager will write to the practitioner within 5 working days of receiving the specialist's and Occupational Health's advice setting out his/her decisions. The Case Manager should confirm whether the matter will be dealt with as an ill health issue or under the capability or conduct procedure as appropriate. If the Case Manager determines the issue is a health issue, he/she should follow the procedure set out above. If he decides the issue is a matter of conduct or capability then that process will continue subject to what is set out below. The remainder of part 4 deals with the further procedure."

80. Having set out those relevant provisions of the Medical Staff Procedure I turn to the question of who is to decide the classification? Is it the Case Manager or the Court? If it is the Court then does the Court review the decision of the Case Manager or reach a fresh (and possibly different) decision?

81. Both counsel refer me to Mattu v University Hospitals Coventry and Warwickshire NHS Trust [2013] ICR 270. In my judgment it is clear that this case is authority for the proposition that the Court decides the classification. See the judgments of Stanley Burnton LJ at paragraphs 31-34; Elias LJ at paragraph 81-88 and Sir Stephen Sedley at paragraphs 134-155 and especially at paragraph 137. However I would also agree with the proposition that the Court ought to be slow to readily interfere with the

conclusion of an experienced case manager on classification (in that case an experienced and independent panel): per Stanley Burnton LJ at paragraph 34 and Elias LJ at paragraph 88.

82. I do not accept Mr Sutton QC's suggestion that Mattu has been undermined by the obiter comments of Lord Hodge JSC in Chhabra at paragraph 41. There is no reference to Mattu in the judgment of Lord Hodge JSC (with whom the other Justices of the Supreme Court agreed).

83. The second question I have to ask under this issue is whether I consider the approach of the Case Manager in classifying the six allegations as misconduct was wrong. I, of course, have the advantage of seeing material which was not before Dr Given-Wilson when she made her decision on 16th December 2013.

84. Mr Hyam submits that first, each of the allegations are wrongly being classified as purely conduct allegations under the Defendant's disciplinary procedure as opposed to (a) health matters or alternatively should have been classified as (2) mixed professional conduct, capability and health allegations. He submits that the evidence suggests that during the period of these allegations, the Claimant's behaviour was entirely out of character and took place when she was suffering from severe mental illness, so that that illness is likely to have caused or at least have materially contributed to her decision-making and emotional responses. Mr Hyam submits that the classification was plainly wrong. In support of that submission he analyses the six allegations and the Claimant's response to them in detail in paragraph 8 of his skeleton argument.

85. Mr Sutton QC submits that the six allegations fall within the ambit of Part 1 paragraph 3.1 of the Medical Staff Procedure and were properly classified by Dr Given-Wilson as the Case Manager as misconduct. In his oral submissions Mr Sutton QC also analysed the six allegations in support of his argument.

86. I prefer the analysis of Mr Sutton QC. I have set out the detail of the allegations above and will not repeat it. What I am concerned with here is the evidence in support of those allegations.

Allegation 1

87. The Claimant deals with this in her witness statement at paragraph 12.5. She says this:

> "At the time (December 2011), my psychiatric illness had a severe impact on my cognitive processing and communication, and I was confused by the convoluted status of this patient and thought a pre-existing NHS referral sufficient."

88. In her letter dated November 15th 2012 for the GMC enquiry Dr Feinmann refers to three causal matters of which only one is "health problems": TB/3/13 paragraph 2. Furthermore, Dr Cashman annexes to his report a letter dated 7th February 2012 from the Claimant to Dr Cashman giving her explanation. The Claimant does not refer there to any mental health problem in relation to her action. It is a detailed and rational explanation that states that her action in referring this patient was correct:

TB/7/78-82. See also the Claimant's contemporaneous letters (December 2011) at TB/7/69-71.

89. Dr Cashman took the view that this was a conduct issue: see his report at TB/7/7 paragraph 5.1.1 and TB/7/14 paragraph 6.1.

90. The question therefore for the Case Manager was whether this evidence was prima facie evidence of a conduct issue. Dr Given-Wilson's answer to this question was in the affirmative. It looked to her like an attempt to circumvent the NHS referral process. Furthermore, she was aware that a conduct hearing could and would consider any ill health issues. I agree.

Allegation 2

91. The Claimant gave an explanation in her letter to Dr Cashman dated 7th February 2012: TB/7/83. It was a detailed explanation which sought to justify her actions. The essence of it was that at the time (within the period of severe mental illness) she was in dispute with a colleague Mr Doumouchtsis.

92. Dr Cashman's view was that this was also a conduct issue. He cited the evidence of Miss Clare Lyons Collins, who was an Assistant General Manager at the time. See paragraph 5.2.1 of his report: TB/7/8. His conclusions are in his report at paragraph 6.2.3-6.2.5 at paragraph 6.2.5 he says this:

> "In conclusion Miss Fynes failed to make appropriate arrangements for explaining the proposed procedure to SB on the day of surgery and obtaining her consent.": TB/7/16.

93. The question is whether the Case Manager is entitled to find that this case could be an issue of fault and therefore appropriate for the conduct panel. In my judgment it was and Dr Given-Wilson was entitled to so find.

Allegation 3

94. The Claimant's explanation is in her witness statement paragraph 12.3. She says that her failure to answer the on-call telephone messages leading to a significant delay in the treatment of gynaecological emergency was because of her illness. She had been suffering from chronic sleep deprivation, anxiety and preoccupation, and her recall was impaired. She missed her telephone ringing (next to her bed) whilst she was asleep at home: TB/2/4-5. In my judgment this was evidence that the Case Manager could say that this was fault and therefore misconduct although there might be an explanation at a conduct hearing.

Allegation 4

95. This relates to the inappropriate management of the gynaecological emergency. The Claimant says this at paragraph 12.4 of her witness statement:

> "I was not aware at the time of the severity of my psychological ill health. My cognitive processing was severely impaired I did not fully comprehend the information given to me and may (my emphasis) have mis-communicated my instructions.": TB/2/5.

96. I also note the Claimant's comments in her letter to Miss Julia Hollywood (for the purpose of her enquiry) dated 14th February 2013: TB/7/473 where the Claimant is attributing blame not to her ill health but to the fault of colleagues. In my judgment that was material which Dr Given-Wilson could properly regard as a matter of conduct.

Allegation 5

97. The Claimant deals with this in paragraph 12.2 of her witness statement. This allegation relates to the attempt to transfer private patients from one private hospital (at which her practising privileges had been suspended) to other hospitals when she did not inform the other two hospitals of the suspension of her practising privileges as was required of her. Miss Fynes' explanation of this is:

> "I learnt of the suspension of my practising privileges by way of a telephone call during a busy all-day clinic, did not know the procedure to take and tried to act in the best interest of my private patients as I saw them at the time, by frantically trying to arrange cover for them elsewhere. My cognition was poor and I was not thinking clearly enough to respond to this call in these circumstances – my illness profoundly impacted on my behaviour and communication skills, particularly in a stressful situation as this.": TB/2/4.

98. This issue is dealt with in the report of Miss Julia Hollywood at TB/7/295: she concludes that the relevant GMC guidance is clear and that the Claimant failed to inform the two hospitals in a timely manner. There was therefore a well founded case for her to answer in relation to her conduct in this matter. Appendix 17a of Ms Hollywood's report is a contemporaneous file note of a conversation between Miss Hilda Bradbury and Miss Fynes. Miss Bradbury was the person who suspended Miss Fynes' practising privileges from Parkside Hospital: TB/7/388-389. See also the note of Ms Hollywood's telephone interview with Miss Bradbury dated 5th July 2012: TB/7/420-421 and the Claimant's explanation in her long letter to Ms Hollywood dated 31st March 2013 at TB/7/457. In my judgment this is clearly material which enables Dr Given-Wilson to form a view that this was a matter of conduct and not ill health and capability.

Allegation 6

99. The Claimant deals with this in paragraph 12.1 of her witness statement. Her explanation for failing to attend a gynaecological emergency on 17th May 2012 was that she was attending a psychiatric out patient's appointment in relation to her illness of which the Trust was aware. She "was within 20 minutes travel time of the hospital, was very anxious and believed the on-call staff were competent to deal with the situation.":TB/2/4.

100. In her letter of 14th February 2013 to Ms Hollywood, the Claimant's explanation is lengthy and is at TB/7/469-70. It is to be noted that some five days later according to that account, Miss Fynes was giving a lecture at the Royal College of Obstetricians and Gynaecologists. Finally, I note the Claimant's answer to the questionnaire sent to her by Ms Hollywood. It is dated 31st March 2013:TB/7/455-456.

101. In my judgment there was more than adequate material for Dr Given-Wilson to find that there was evidence of misconduct and that a conduct enquiry was appropriate.

102. I have examined all the material put in front of me and am firmly of the view that each one can be said to properly raise a case of misconduct such as to justify the Claimant appearing before a conduct inquiry. I note the modifications to the procedure to the inquiry which in my judgment will fully cater for the health concerns raised by the Claimant.

Issue 5: Whether in all the circumstances, an injunction should be granted restraining the proposed disciplinary hearing and if so on what terms?

103. It follows from my analysis set out above that I refuse an injunction restraining the proposed disciplinary hearing because both Dr Given-Wilson has properly classified the six allegations as allegations of conduct and I have myself done so on the information both before her and before me. There is no breach of contract.

104. It also follows that I refuse the declaration for the same reasons.