

IN THE HIGH COURT OF JUSTICE
COURT OF APPEAL (CIVIL DIVISION)
ON APPEAL FROM QUEEN'S BENCH DIVISION
MR JUSTICE UNDERHILL
08IHQ0483

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 30th March 2010

Before:

LORD JUSTICE WARD
LORD JUSTICE WILSON
and
LORD JUSTICE TOULSON

Between:

Gillian Clare Mezey	Respondent
- and -	
South West London & St George's Mental Health NHS	
Trust	Appellant

(Transcript of the Handed Down Judgment of
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Official Shorthand Writers to the Court)

Mr P. Havers QC and Ms L. Millin (instructed by Capsticks) for the appellant
Mr J. Hendy QC and Mr J. Davies (instructed by Radcliffes Le Brasseur) for the respondent

Hearing date: 27th October 2009

Judgment
As Approved by the Court

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Lord Justice Ward:

1. On 5th December 2008 Dr Gillian Mezey, a consultant forensic scientist employed by the South West London and St George's Mental Health NHS Trust ("the Trust") was granted an injunction by Underhill J. restraining the Trust from holding any disciplinary hearing or disciplining her directly or indirectly in consequence of, or in connection with, the findings of the Panel chaired by Mr Robert Francis Q.C. contained in its report of 28th March 2008. The Trust now appeals.

Background

2. A terrible tragedy is the backdrop to this appeal. John Barrett ("JB") first had contact with the psychiatric services in 1997 when he was admitted to Springfield Hospital on an informal basis. By then he had many convictions including convictions for robbery and affray. He was detained under section 2 of the Mental Health Act 1983 after reports that he had threatened to kill a complete stranger to him. He was suffering from a persistent delusional disorder and/or paranoid schizophrenia. In 2002 whilst in the waiting room of a general hospital clinic he stabbed and seriously injured three people. As a result, a hospital restriction order was made under sections 37 and 41 of the Mental Health Act 1983 "for the protection of the public from serious harm". In October 2002 his care was transferred to Dr Mezey who held the dual positions of consultant forensic psychiatrist at the Springfield Hospital and as Reader in Forensic Psychiatry at St George's Medical School.
3. On 10th October 2003 a Mental Health Review Tribunal decided that JB should be conditionally discharged. There was no cause for criticism of Dr Mezey's care and management of her patient up to the time of the Tribunal's decision.
4. During the months that followed JB was seen regularly and frequently by Dr Mezey and her team. He was readmitted to an open ward of the hospital for five days in May 2004. During July 2004 his partner and family members expressed concerns to members of the care team that he was becoming mentally unwell. In August, there were reports of specific incidents where his behaviour suggested he was again becoming paranoid. No criticisms of Dr Mezey's care and management of his case were established up to this point.
5. Dr Mezey had been on leave in August and on her return on 31st August 2004 she learnt of the deterioration in his mental state and arrangements were made to persuade him when he attended the hospital the next day to accept voluntary admission to a medium secure unit. That duly happened. He was, however, granted one hour's unescorted garden leave which allowed him to use a small garden area which was fenced but the fence could be climbed by an athletic individual. He took that leave at about 3 pm on 1st September 2004 and absconded. Dr Mezey was that day delivering a speech at a Home Office conference so was not herself able to examine him nor was she informed of his absconding until the following day. Before he could be recalled the underlying tragedy occurred: on 2nd September 2004 at about 10 am JB attacked a stranger, Mr Dennis Finnegan, in Richmond Park with a knife and killed him.

The ensuing events

6. The hospital set up its own internal enquiry chaired by Ms Judith Chegwiddden into “the care and treatment of John Barrett and the events leading up to the homicide of Dennis Finnegan on 2nd September 2004”. She reported in March 2005. The Trust then decided to conduct an investigation into Dr Mezey’s role in the care of JB and Dr Geraldine Fitzpatrick, associate medical director at the London Borough of Merton, published her report on 18th July 2005. In view of the criticisms she made, the hospital decided to proceed to a formal hearing. It was initially proposed that this be conducted in accordance with the Department of Health’s Framework, known as “Maintaining High Professional Standards in the modern NHS” (“MHPS”), about which more later, but, for some reason, the Trust had not yet implemented those procedures as it should have done. Amidst that confusion and after discussion between solicitors, it was agreed in December 2005 that the Trust would proceed under the Department of Health’s circular “Disciplinary Procedures for Hospital ... Staff”, HC(90)9 (“HC(90)9”) to which I must also refer later. By letter dated 6th April 2006 the Trust informed Dr Mezey that a panel would be convened under Annex B of HC(90)9 to conduct a formal investigation into Dr Mezey’s care of JB.
7. Robert Francis Q.C. was appointed to conduct this enquiry with Dr Michael Hobbs, a consultant psychiatrist and Dr Stephen Barlow, a consultant forensic psychiatrist. Their terms of reference were:

“1. To consider the appropriateness of the decision by GM to admit Mr Barrett on 1st September 2004

(a) as a voluntary patient to the Shaftesbury Clinic

(b) as a voluntary patient to the Haswell Ward which is a secure unit

(c) without informing the Home Office of the deterioration in his condition which preceded the decision to admit him and the decision to admit him as a voluntary patient to a secure ward.

2. To consider the appropriateness of the decision by GM on 1st September 2004 to grant unescorted leave to Mr Barrett without adequate clinical assessment.

3. To consider whether the care and treatment of Mr Barrett by GM and her clinical supervision of his case in the period between 10th October 2003 and 1st September 2004 was appropriate.”

8. Particulars of paragraph 3 of the terms of reference were given subsequently by the Trust, namely:

“1. The discharge care plan was not adequately implemented.

2. Mr Barrett was not seen regularly as required.

3. There was no effective system for medical supervision of his case when he was an out-patient.

4. Communications by GM with her clinical team as to care and treatment and level of risk were inadequate.
 5. There was no adequate consideration and response to collateral information from family and close friends of Mr Barrett as to change in his medical state, behaviour and level of risk.
 6. There was a failure to recognise the level of risk associated with a deterioration in his mental state.
 7. Reporting to the Home Office as to the care and treatment of Mr Barrett, changes in his mental state and level of risk was irregular and inadequate.”
9. Meanwhile JB had been convicted of manslaughter on 25th February 2005 and a further inquiry was commissioned in accordance with the Department of Health’s circular “The discharge of mentally disordered people and their continuing care in the community”. The resulting report of Dr Robinson was delivered on 30th October 2006.
 10. This report led Mr Peter Houghton, the Chief Executive of the Trust, to suspend Dr Mezey from all her duties which she had until then continued to perform, not only in the clinical care of her patients but also in her teaching at the medical school. She challenged this suspension by bringing a claim for relief in the Queen’s Bench Division and on her undertaking not directly or personally to assess, treat or care for patients of the Trust, Underhill J. ordered on 19th December 2006 that the suspension be lifted. His judgment is reported as *Mezey v South West London and St George’s Mental Health NHS Trust* [2007] IRLR 237.
 11. The Francis panel met for the first time on 17th November 2006, heard evidence for 9 days in November 2007 and reported on 28 March 2008 (“the Francis Report”). I shall elaborate on it later and it is sufficient for the context of the present résumé of events simply to state that the principal conclusions were that although Dr Mezey’s decision with regard to unescorted leave was inappropriate, that did not amount to serious professional incompetence: the Trust had failed to prove that she had been “at serious fault”.
 12. Despite Dr Mezey’s solicitor’s protests that no disciplinary action should be taken, the Trust determined otherwise. At first the Trust proposed in a letter dated 20 May 2008 to set up a disciplinary hearing under the “Trust’s Disciplinary Procedure” to consider her decision to allow unescorted ground leave before she had personally assessed the patient and also to consider the failure to submit reports to the Home Office. The Trust proposed to hold a disciplinary hearing on 9th June to consider whether or not any disciplinary action, up to and including dismissal, should be taken against her. Until the conclusion of the hearing she should not return to her clinical duties.
 13. That led Dr Mezey to bring this claim for injunctive relief prohibiting the Trust from holding a disciplinary hearing and from continuing to exclude her from clinical work. That forced the Trust to reconsider its position and on 9th June 2008 the Trust’s solicitors wrote as follows:

- “1. The Trust agrees to lift Dr Mezey’s suspension/exclusion from clinical work ...
 2. The Trust does propose to convene a disciplinary hearing to consider the findings of the Francis Report. The Trust does not accept that this is a matter that should be dealt with by way of an informal meeting. The hearing will be in accordance with MHPS 2003/2005. However, the sanction, if any, that the Trust imposes on Dr Mezey in respect of the findings of the Francis Report will exclude dismissal.”
14. Dr Mezey duly resumed her full range of duty from her clinical work to her teaching position and there is now no suggestion from the Trust that that should change or that she should be dismissed whatever the outcome of any disciplinary proceedings. Whether such disciplinary proceedings should be permitted and if so what sanction should be imposed were the principal issue for Underhill J. to resolve. As I have recited in paragraph 1, on 5th December 2008, he restrained the Trust from holding disciplinary proceedings.

The contractual relationship between the parties and the available disciplinary procedures

15. The contractual position was not entirely clear to me and I am grateful to counsel, Mr Philip Havers Q.C. for the Trust and Mr John Hendy Q.C. for Dr Mezey, for their clarifying responses to the queries I raised after the conclusion of oral argument.
16. As I now understand it, the position is this. In 1991 Dr Mezey was appointed as a consultant forensic psychiatrist by the statutory predecessor to the Trust. The exact terms of her engagement do not now matter for it is common ground that professional disciplinary matters were regulated by the Department of Health Circular HC(90)9 on “Disciplinary Procedures for Hospital ... Staff” (“HC(90)9”) to which I referred earlier.

HC(90)9

17. This circular was issued in March 1990 and consolidated previous guidance. It provided that the procedure to be followed depended on the nature of the allegation of misconduct and applied the following definitions:

“PERSONAL CONDUCT – Performance or behaviour of practitioners due to factors other than those associated with the exercise of medical or dental skills.

PROFESSIONAL CONDUCT – Performance or behaviour of practitioners arising from the exercise of medical or dental skills.

PROFESSIONAL COMPETENCE – Adequacy of performance of practitioners related to the exercise of their medical or dental skills and professional judgment.”

The allegations against Dr Mezey clearly fell into the “Professional Competence” category. Annex B provided for the “Disciplinary Proceedings in cases relating to the Hospital ... Staff ...”. It gave guidance on the procedure to be followed “in serious disciplinary cases involving hospital ... doctors”. It outlined the procedures which health authorities should use “when handling serious disciplinary charges, for example, where the outcome of disciplinary action could be the dismissal of the medical or dental practitioner concerned”. The first step in cases involving professional conduct or professional competence was to consider whether there was a prima facie case which, if well founded, could result in serious disciplinary action such as dismissal. If so, an inquiry by an investigating panel should be held. The guidance provides:

“14. The report of the investigating panel should be presented in 2 parts. The first part should set out the committee’s findings and all the relevant facts of the case, but contain no recommendations as to action. The second part should contain a view as to whether the practitioner is at fault, and may, at the request of the Authority appointing the panel, contain recommendations as to disciplinary action. In no circumstances should the investigating panel itself be given disciplinary powers.

15. The panel should send the practitioner a copy of the first part of their report, and should allow a period of four weeks for the submission to them of any proposals for corrections of fact, or for setting out in greater detail the facts on any particular matter which has arisen. It would be for the panel to decide whether to accept any proposed amendments and whether any further hearing was necessary to enable them thus to decide. Subject to this procedure, the facts as set out in the panel’s report should be accepted as established in any subsequent consideration of the matter.

16. The Authority should then receive the full report of the investigating panel and decide what action to take. In the event of the investigating panel finding that the practitioner is at fault, the substance of their views on the case and recommendations in the second part of their report should be made available to him in good time before the meeting of the Authority and he should be given the opportunity to put to them any plea which he may wish to make in mitigation before they reach any conclusion as to action.”

18. Annex E provided for an “intermediate procedure” which involved the use of independent professional assessors to investigate and advise on less serious matters involving professional conduct or competence. The Director of Public Health would then determine whether the allegations of professional conduct or competence were serious enough to warrant the procedures under Annex B of the circular or whether they involved less serious allegations about professional conduct or competence and so were suitable for this intermediate procedure. Assessors would be appointed and, as in cases under Annex B, they would prepare a report in two parts, the first setting

out their findings of fact with no recommendations as to action and the second part containing a view as to whether and to what degree the doctor involved was at fault, which could contain recommendations. The Director of Public Health would then consider what further action was necessary. "If he decided that disciplinary action was necessary, e.g. a warning was appropriate", then local procedures based on the ACAS code of practice would be followed.

19. It will have been observed that apart from the examples of dismissal or warning, there was no indication in HC(90)9 as to the range of disciplinary action that could be taken except to the extent that paragraph 1 of Annex B provided that it was to be used "when handling serious disciplinary charges, for example, where the outcome of disciplinary action could be the dismissal of the medical ... practitioner concerned."

Maintaining High Professional Standards in the Modern NHS 2003/2005 ("MHPS")

20. In December 2003 the Department of Health issued its framework document, MHPS, for the handling of concerns about doctors in the NHS. It was in two parts, Part I dealing with "Action when a concern arises" and Part II with "Restriction of practice and exclusion." In 2005 the Department agreed with the British Medical Association three more parts, Part III dealing with "Conduct hearings and disciplinary matters", Part IV with "Procedures for dealing with issues of capability" and Part V with "Handling concerns about a practitioner's health". The document proclaimed that the new procedure was to replace the procedures contained in HC(90)9 and recorded that the Directions on Disciplinary Procedures 2005 required all NHS bodies to implement the framework within their local procedures from 1 June 2005.
21. The Secretary of State in exercise of his statutory powers duly issued Directions on Disciplinary Procedures 2005 prescribing that MHPS was to come into force on 17th February 2005 and requiring all NHS trusts to implement the framework by 1 June 2005. These Directions declared for the avoidance of doubt that the Disciplinary Procedures HC(90)9 were withdrawn.
22. The Trust does not seem to have complied with that Direction at all expeditiously. Indeed, counsel in their joint response inform us that the Trust consider that MHPS was only implemented on 27th September 2006. I confess I still do not know how this was done and whether it became incorporated into Dr Mezey's contract of employment. The Trust apparently did issue a new Consultant's Contract, probably in November 2006 (the dates are a little unclear but it may not matter), paragraph 17 of which provided for Disciplinary Matters as follows:

"Should we consider that your conduct or behaviour may be in breach of our code of conduct, or that your professional competence has been called into question, the matter will be resolved through our disciplinary or capability procedures (which will be consistent with 'Maintaining High Professional Standards in the Modern NHS framework', subject to the appeal arrangements set out in that framework)."

23. The Trust set out its procedures in a document called "Disciplinary Policy and Procedure" dated 8 November 2006. Its stated purpose and scope was that the policy should apply to medical staff under the disciplinary framework, MHPS, but only in

respect of “any issues relating to conduct”, not capability. The procedure was designed to support and encourage all members of staff to achieve and maintain “standards of conduct” and to provide “a fair and impartial method for dealing with allegations of misconduct.” The stated principles which applied were that the procedure “should primarily be viewed as a mechanism to allow an improvement in conduct. Staff should not be dismissed for an initial breach of conduct except for cases of gross misconduct.”

24. It is common ground that this disciplinary policy and procedure solely addressed issues relating to conduct, not capability, and thus has no application to the allegations in this case. That no doubt explains why the Trust abandoned its first proposal to set up the disciplinary hearing under the Trust’s Disciplinary Procedure. The stance it adopted in the letter of 9th June 2008 (see [13] above) was to proceed with a hearing in accordance with MHPS 2003/2005. Whether or not that was ever incorporated into the contract of employment does not matter for the purposes of this appeal because the common ground appears to be that it is the only procedure available to the Trust and the appeal has been argued on the basis that the power to hold a disciplinary hearing is governed by this framework and its terms dictate what sanctions the Trust may impose on Dr Mezey in the light of the findings of the Francis Report, save that, as already set out, the sanction would exclude dismissal. The case presented to us was that a reprimand would be the appropriate disciplinary sanction. So it is necessary to consider MHPS 2003/2005 in some detail.
25. It introduced a new procedure to replace HC(90)9. The key changes included the abolition of the distinction between personal and professional misconduct and the establishing of a single process for handling capability issues about the practitioner’s professional competence to be closely tied in with the work of the National Clinical Assessment Authority (“NCAA”), now the National Clinical Assessment Service. All NHS organisations were required to have procedures for handling concerns about the conduct, performance and health of medical employees. The background was that for a number of years there had been concern about the way in which complaints about, and disciplinary action against, doctors were handled in the NHS and particularly about the use of suspension in such cases. Developing new arrangements for handling issues about medical staff performance had become increasingly important both to tackle concerns about the exclusion from work of doctors and to reflect the new system for quality assurance and quality improvement which had been introduced in the NHS in recent years. The new approach built on four key elements, one of which was using the advisory and assessment services of the NCAA “aimed at enabling NHS trusts to handle cases quickly and fairly, reducing the need to use disciplinary procedures to resolve problems”. The fourth “key element” was this:

“4. But to work effectively these [new arrangements] need to be supported by a culture and by attitudes and working practices which emphasise the importance of doctors and dentists keeping their skills and knowledge up to date; maintaining their competence; and which support an open approach to reporting and tackling concerns about doctors’ and dentists’ practice. The new approach recognises the importance of seeking to tackle performance issues through training or other remedial action rather than solely through

disciplinary action. However it is not intended to weaken accountability or avoid disciplinary action where there is genuinely serious misconduct.”

26. Part I of the circular describes the “Action when a concern arises”. All NHS bodies must have procedures for handling serious concerns about an individual’s conduct and capability. A serious concern about capability will arise where the practitioners’ actions have or may adversely affect patient care. The duty to protect patients is paramount and “at any point in the process where the case manager has reached the clear judgment that a practitioner is considered to be a serious potential danger to patients or staff, that practitioner must be referred to the regulatory body whether or not the case has been referred to the NCAA”. A summary of the key actions is given:

“●clarify what has happened and the nature of the problem or concern;

● discuss with the NCAA what the way forward should be;

● consider whether restriction of practice or exclusion is required;

● if a formal approach under the conduct or capability procedures is required, appoint an investigator;

● if the case can be progressed by mutual agreement consider whether an NCAA assessment would help clarify the underlying factors that led to the concerns and assist with identifying the solution.”

27. The report of the investigation should give the case manager sufficient information to make a decision whether, among other things:

“● there are concerns about the practitioner’s performance that should be further explored by the NCAA;

...

● there are serious concerns that should be referred to the GMC ...

● there are intractable problems and the matter should be put before a capability panel

● no further action is needed.”

The focus of the NCAA’s work is likely to involve performance difficulties which are serious and/or repetitive, i.e. performance falling well short of what doctors and dentists could be expected to do in similar circumstances and which, if repeated, would put patients seriously at risk.

28. Part II of the circular deals with restriction of practice and exclusion from work when serious concerns are raised about a practitioner. The exclusion process cannot require

the exclusion of a practitioner for more than four weeks at a time and justification for continued exclusion must be reviewed on a regular basis and before any further four week period of exclusion is imposed. The total period must not be prolonged.

29. Part III deals with conduct hearings and disciplinary matters. The case before us is not a case of misconduct.
30. We are concerned with Part IV, "Procedures for dealing with issues of capability." The general principles enunciated include:

"3. However, there will be occasions where an employer considers that there has been a clear failure by an individual to deliver an adequate standard of care, or standard of management, through lack of knowledge, ability or consistently poor performance. These are described as capability issues. Matters that should be described and dealt with as misconduct issues are covered in Part III of this framework.

4. Concerns about the capability of a doctor or dentist may arise from a single incident or a series of events, reports or poor clinical outcomes. Advice from the National Clinical Assessment Authority (NCAA) will help the Trust come to a decision on whether the matter raises questions about the practitioner's capability as an individual (health problems, behavioural difficulties or lack of clinical confidence) or whether there are other matters that need to be addressed. If the concerns about capability cannot be resolved routinely by management, **the matter must be referred to the NCAA before the matter can be considered by a capability panel** (unless the practitioner refuses to have his or her case referred). Employers are also strongly advised to involve the NCAA in all other cases particularly those involving professional conduct." (The bold emphasis is in the original framework.)

31. The framework sets out the duties of employers as follows:

"9. The procedures set out below are designed to cover issues where a doctor's or dentist's *capability* to practise is in question." (Again the emphasis is in the document.)

32. The stated capability procedure includes a pre-hearing process conducted by the case manager. If the matter cannot be resolved through local action the matter must be referred to the NCAA which will assist the employer to draw up an action plan designed to enable the practitioner to remedy any lack of capability that has been identified during the assessment. If the practitioner's performance is "so fundamentally flawed that no educational and/or organisational action plan has a realistic prospect of success", then the case manager must make a decision whether the matter should be determined under the capability procedure. If so a panel hearing will be necessary. The framework prescribes how that hearing will be set up and how the hearing should be conducted. Arrangements must be made for the panel to be

advised by a senior clinician from the same or similar clinical specialty as the practitioner concerned.

33. The framework then provides for the decisions to be made as follows:

“24. The panel will have the power to make a range of decisions including the following:

Possible decisions made by the capability panel

- No action required.
- Oral agreement that there must be an improvement in clinical performance within a specified time scale with a written statement of what is required and how it might be achieved. (*Stays on employee's record for six months*).
- Written warning that there must be an improvement in clinical performance within a specified time scale with a statement of what is required and how it might be achieved. (*Stays on employees record for six months*).
- Final written warning that there must be an improvement in clinical performance within a specified timescale with a statement of what is required and how it might be achieved. (*Stays on employee's record for one year*).
- Termination of contract.

It is also reasonable for the panel to make comments and recommendations on issues other than the competence of the practitioner, where these issues are relevant to the case. For example, there may be matters around the systems and procedures operated by the employer that the panel wishes to comment upon.”

34. Provision is also made for appeals but that does not concern us.

The Francis Report

35. As I have indicated, this panel of enquiry was set up under the auspices of Annex B of HC90(9) with particular reference to paragraphs 14 and 15 which are recited at [17] above. The panel construed its task to be restricted in the first instance to reporting its findings of fact in relation to the allegations raised by the Terms of Reference and secondly to state its view as to whether Dr Mezey (“GM” in the report) was at fault. They noted that the Terms of Reference invited them to make findings as to whether the decisions and management of JB by GM were “appropriate” in various respects. They construed that as follows:

“Before finding that GM acted in a way which was “inappropriate” we will have to be satisfied that her acts or omissions fell below the standards of any responsible and competent consultant forensic psychiatrist. Where her decisions and management have the support of an expert or experts who genuinely hold the view that she performed in accordance with the opinions of a body of responsible and competent consultants, the panel can only find that her decisions or management were inappropriate if satisfied that the views of the experts are incapable of withstanding logical analysis, after recognising that genuinely held expert views will fall into such a category.”

36. The panel found that there was no cause for criticism of GM’s care and management of the process leading up to the Mental Health Review Tribunal’s decision in October 2003. Although the Tribunal found that GM had failed to comply with the standards of good practice and was in breach of the Home Office requirements in failing to ensure that psychiatric supervisors’ reports were submitted to the Home Office when required, that failure was contributed to by the relevant SpR and by the Home Office itself. Moreover it was commonplace in forensic services generally at the time for reports on restricted patients to be late or not sent at all. As for the period from JB’s discharge by the Mental Health Review Tribunal in October 2003 to the decision of 31st August 2004 to offer voluntary admission, the panel found that the discharge plan was adequately implemented; that JB was seen regularly and frequently; that JB was adequately medically supervised during the period under review; that communications between GM and her team were not inadequate – on the contrary there were many examples of good practice to be seen; such failure as there was to recognise a deterioration in mental state and increase in level of risk took place in GM’s absence and was not a failure for which she was responsible; but GM failed to ensure that the Home Office received medical supervisor’s reports as required. It was appropriate to admit JB as a voluntary patient to a medium secure unit.

37. The focus of the case was on the decision to grant JB unescorted leave. As to this the Panel found:

“26.1 ... we accept without reservation that GM is a highly experienced, conscientious and distinguished clinician and academic. We are not aware of any concern about her competence or conduct before this case, and assume there has been none. She gave her evidence to us honestly and candidly.”

38. Nonetheless the panel went on to find that:

“27.22 ... even though we have accepted that other competent consultants at the time might have made the same decision, we are satisfied that the decision to grant unescorted ground leave on 1st September without GM seeing the patient personally was unjustified, and inappropriate. ...

27.23 Therefore we find that it was inappropriate for GM to grant unescorted leave to JB before undertaking a personal clinical assessment.”

39. The panel gave a helpful summary of its findings:

“28.1 We are satisfied that GM failed to comply with the standards of good practice and was in breach of Home Office requirements in failing to ensure that psychiatric supervisor’s reports were submitted to the Home Office when required. However this failure was contributed to by the relevant SpR and by the Home Office itself.

28.2 We found no other cause for criticising GM’s management of JB’s case between October 2003 and August 2004.

28.3 We found that there was possibly an inadequate reaction on the part of the team to reports of concerns in August but GM was not and could not have been responsible for any failings in this regard as she was absent on leave.

28.4 The decision to offer voluntary admission on 1st September was appropriate and in accordance with acceptable and tenable medical opinion.

28.5 We accept that the decision to allow unescorted ground leave to be taken on 1st September was within a range of opinion that could be held by competent practitioners but we are satisfied that in the circumstances known to GM at the time it was not justifiable to allow such leave before she had personally assessed the patient.”

That concluded Part I of the Report.

40. Turning to Part II of their Report, the panel had to indicate the extent to which, if at all, the findings of fact they had made amounted to evidence of serious professional incompetence or misconduct. They made these findings:

“30. Background

We start by repeating that we found GM to be generally a competent, conscientious and distinguished practitioner. She has made significant contributions to the practice of forensic psychiatry both with her employing Trust and more generally. Before this case there was no expression of concern. As indicated above we have accepted in its entirety the testimonial evidence placed before us. ... That evidence can be taken as demonstrating

- Her commitment to the welfare of her patients

- Her commitment to the supervision and training of staff
- The unqualified respect with which she is held by her professional peers
- A reputation for sound clinical judgment
- An ability to work with a team
- An ability to listen to the views of others
- Her success as a manager of services
- Her nationally and internationally recognised status in academic research in forensic psychiatry

In short she is someone who is widely regarded as an asset to the profession.

31. Reporting

...

31.4 We consider it highly unlikely that GM will fail to comply with the formal requirements for reporting in respect of restricted patients in the future.

31.5 In these circumstances we consider that our findings with regard to reporting do not in themselves give rise to any cause for concern.

32. Grant of unescorted leave

32.1 We have found that it was inappropriate and not in accordance with the standards of good practice for GM to grant unescorted ground leave on 1st September. However we accepted that GM acted in the same manner as would at least some other reasonably competent professionals in the field, even though we consider that such a practice is not one which withstands logical scrutiny.

32.2 In deciding what, if any fault in the sense described is to be attributed to this criticism, the following factors are relevant:

32.2.1 The decision was made in the reasonable expectation that if JB did not return when required to do so, that urgent steps would be taken to alert various authorities, to seek to locate him and to arrange for his recall. That no such steps were taken is not GM's responsibility. It is distinctly possible in our view that if such steps had been taken that JB would have been located and detained before this tragedy occurred.

32.2.2 The decision was taken with the concurrence of Ms Sturdy [the social supervisor] and other members of the team. While this does not exempt GM from her own responsibilities, her discussions with her colleagues suggest a willingness to take into account the views of other professionals. She was not imposing a decision on colleagues who had serious concerns about its correctness. Such concerns as were expressed were more about the consequences of having JB as a voluntary patient; they were not about the granting of leave.

32.3.3 GM was undoubtedly at a disadvantage in having to make decisions about this patient when absent from hospital. While we have found that she should have deferred this decision until she personally had seen the patient, she was trying to do her best in his interests while at the same time coping with the demands of her commitment to the Home Office. Given her academic commitments she would have become accustomed to managing matters concerning her patients remotely on a regular basis.

32.2.4 GM possesses insight into the matter. She accepts that she would now deal with this sort of case differently. We accept her evidence on this and are satisfied that she has learnt appropriately the lessons to be learnt. While she has sought to justify her decision this has only been by reference to what she knew at the time and the fact that she does so does not in our view indicate lack of insight.

32.2.5 Given that GM is an obviously conscientious and competent consultant psychiatrist we do not regard her mistake with regard to this decision, one which might well have been made by others, indicates any cause for concern that she is likely to put other patients or the public at risk in the future if she were to continue in forensic hospital practice, whether or not combined with academic duties.

32.2.6 While we have not heard evidence from or been asked to make judgments about others involved in the care of JB, on what we have seen the mistake we have identified GM as making, in granting unescorted leave, is significantly less serious than mistakes made by those who knew that JB had absconded but then failed to alert GM or the relevant authorities.

32.3 Strictly speaking the seriousness or otherwise of the mistake we find was made should be judged without reference to the tragic events which followed. However, even if we were to consider what occurred, we are quite unable to say that something similar might not have occurred even if GM had been able to make a personal assessment of the patient. It may

have been the case that this would have reassured her appropriately that there was no cause for concern and leave may still have been granted.

33. Conclusion

33.1 We therefore find that although GM's decision with regard to unescorted leave was inappropriate, we do not find that this amounts to serious professional incompetence.

33.2 We have also considered whether our adverse findings when taken together give cause for concern which does not arise from a separate consideration of them. We do not find that, cumulatively, our findings give rise to such concern.

33.3 In conclusion we do not find that the Trust has proved that GM has been at serious fault with regard to the matters we have found proved." [The bold highlighting is in the Report.]

The judgment

41. The judge accepted Mr Hendy's submission that the Trust could only proceed with a disciplinary hearing if the investigating panel had made a finding of fault. He rejected his submission that "fault" within the meaning of paragraphs 14 and 16 of Annex B of HC90(9) was confined to serious professional incompetence. He held that the term "fault" would naturally cover any fault of any degree. The criticisms identified by the Francis panel plainly amounted to findings of fault, albeit it 'non-serious' fault.
42. Mr Hendy's second submission was that in the particular circumstances of the case no disciplinary action could properly follow from the findings made in the Francis Report and that there was thus no purpose in the hearing because none of the options set out in paragraph 24 of Part IV of MHPS was even arguably appropriate. 'Termination of contract' had already been ruled out. The remaining three options, which were in effect all forms of warning that an improvement in clinical performance was required, were ruled out by the panel's finding that the claimant was and remains 'an obviously conscientious and competent consultant psychiatrist', who had learnt such lessons as were to be learned from what happened in JB's case and in respect of whom there was no cause for concern. The judge accepted that submission. It seemed to him that:

"41. ... warnings of the kind contemplated in paragraph 24 of MHPS would be quite inappropriate in the circumstances of this case and could not be justified. Mr Supperstone [who appeared for the Trust below] made no positive case to the contrary, limiting himself to the submission that all options (save dismissal) were open."

So the real question for the judge was whether it was open to the Trust, either in principle or on the facts of the case, to take some other form of disciplinary action, i.e. beyond those specified.

43. He went on:

“43. In those circumstances I canvassed during oral submissions the possibility that it might be open to the Trust to administer a 'reprimand' or 'admonition' or to make some other formal expression of its disapproval of the fact that the claimant had on this occasion fallen below proper professional standards. ... I will use the term 'reprimand' as a convenient compendious term for a sanction of this kind. The essence of such a reprimand is a formal statement that the person reprimanded has done something wrong. Though it has as such no substantial consequences it is, to put it no higher, an unpleasant thing to happen and to have on one's record and may properly be regarded as a disciplinary sanction.”

He held there was no reason in principle why a power to administer a formal reprimand should not be implied.

44. He concluded:

“45. The real question in my judgment comes down to whether on the facts of this case it would be reasonably open to the Trust to administer a formal reprimand to the claimant. Mr Hendy submitted that it would not be. After careful consideration, I accept that submission. What the investigating panel found was that the claimant had made a single 'mistake' in a matter of clinical judgment, and, what is more, that the judgment in question, albeit that they held it to be wrong, was 'in accordance with a range of opinion that might be held by competent professionals in the field'. There was no finding of any other culpable element, such as carelessness (in the layman's sense) or inadequate consultation with colleagues or anything of that kind. On the contrary, the panel went out of their way to emphasise that the claimant was a highly regarded, conscientious and competent practitioner. This was therefore, on the findings made, a case of a pure 'one-off' misjudgement. Few professionals, however eminent, could not claim to have made such misjudgements occasionally.”

45. So in short he did not believe that the findings made by the panel were capable of justifying disciplinary action and so it was not open to the Trust on the basis of the Francis Report to impose any disciplinary sanction on the claimant. He granted the injunction accordingly.

A summary of counsel's submissions

46. Mr Havers submitted that the short point was whether the Court was entitled to prevent the employer holding a disciplinary hearing to determine whether or not it was appropriate to impose a disciplinary sanction on the employee solely on the basis of the court's assessment in advance of that hearing as to what on the facts it was open to the disciplinary panel to do. He says that it is for the panel, not for the court, to assess the case, the findings of the Francis inquiry and the mitigation and then to decide what is appropriate. The judge's error was to pre-judge what the panel had to decide, especially bearing in mind that this would be a specialist tribunal. A reprimand was a sanction open to it.
47. The thrust of Mr Hendy's submission was that the purpose of the capability procedure was to improve future performance. It is only when performance is found to be fundamentally flawed that the matter could go before the panel. That was a condition precedent. Having the benefit of the Francis Report shows that there was no issue of lack of capability, there was no local action necessary, no reference to the NCAA and there should therefore be no panel. That was the gist of what the judge was deciding. He attacked, but on a much more subsidiary level, the judge's finding that fault had been established and he also submitted it was wrong to imply a power to reprimand.

Discussion

48. I have not found it easy to see this case in a principled way. It is, therefore, necessary to step back a little and remind myself that we are not looking at the powers of a professional body to exercise its disciplinary powers, including reprimands, over its members, nor are we conducting a judicial review of an administrative decision. We are concerned with granting an injunction to restrain a threatened breach of contract. It is therefore essential to establish the terms of the contract and the contractual power not only to impose a reprimand but also, as the antecedent question, the power to hold a disciplinary hearing at all.
49. That is where the trouble and confusion in the case arises. At the time when the decision was taken in April 2006 to start disciplinary proceedings, HC(90)9 was the contractual vehicle for conducting it because, despite the Secretary of State's Directions on Disciplinary Procedures 2005 having withdrawn that guidance and substituted MHPS for it as from 17th February 2005, MHPS had not actually been implemented by the Trust. So the Francis panel was set up to conduct its inquiry in the manner dictated by paragraph 14 of Annex B of HC(90)9 and thus to set out in the first part "the Committee's findings and all the relevant facts of the case" and to give a view in the second part "as to whether the practitioner is at fault." By 2008 when the Trust was able pursuant to paragraph 16 of Annex B to decide what action to take in the event of the investigating panel finding that the practitioner [was] at fault, MHPS had been implemented and the common ground between the parties, and we must accept it, is that by then this formed the only contractual basis for holding disciplinary proceedings and for imposing sanctions.
50. We are thus faced with a hybrid. The first gateway to launching a disciplinary hearing is a conclusion by the investigating panel – the Francis panel – that Dr Mezey was "at fault". Although the disciplinary proceedings were conducted in accordance with Annex B involving "serious disciplinary charges, for example where the outcome of the disciplinary action could be the dismissal of the medical practitioner concerned" and not under Annex E, involving less serious allegations of professional

competence, in both cases the trigger for the exercise of disciplinary powers is the finding of fault. I agree with the judge that fault means fault of any kind, not necessarily serious fault. Had HC(90)9 continued to prevail, the Trust would clearly have been able to decide what further action was necessary, whether it be dismissal under Annex B or other “disciplinary action ... e.g. a warning” under Annex E.

51. Where this case gets difficult is in marrying the MHPS procedure into the HC(90)9 procedure because the threshold into MHPS is completely different. A “key change” was to introduce “a single process for handling capability issues about professional competence closely tied in with the work of the National Clinical Assessment Authority.” It was “a new system for quality assurance and quality improvement” “reducing the need [through use of the NCAA] to use disciplinary procedures to resolve problems”. Paragraph 4 of the “Introduction and Explanatory Note” set out in [25] is worth repeating:

“But to work effectively these [new arrangements] need to be supported by a culture and by attitudes and working practices which emphasise the importance of doctors and dentists keeping their skills and knowledge up to date; maintaining their competence; and which support an open approach to reporting and tackling concerns about doctors’ and dentists’ practice. The new approach recognises the importance of seeking to tackle performance issues through training or other remedial action rather than solely through disciplinary action. However it is not intended to weaken accountability or avoid disciplinary action *where there is genuinely serious misconduct.*” (Emphasis added by me.)

52. The procedure that is adopted under MHPS is different from that in HC(90)9. The first task of the case manager is to assess the likelihood that the problem can be resolved without resort to formal disciplinary procedures and that decision should be taken in consultation with the NCAA. If the formal route is to be followed, a case investigator must establish and report his findings. This is a process akin to the function of the Francis panel. It can lead to a capability hearing. Part IV of MHPS is now in place.
53. Part IV lays down the procedure for dealing with issues of capability. The first question, therefore, is what is a capability issue? The answer is given in paragraph 3 namely:

“However, there will be occasions where an employer considers that there has been a clear failure by an individual to deliver an adequate standard of care, or standard of management, through lack of knowledge, ability, or consistently poor performance. These are described as capability issues.” (The emphasis is added by me.)

Here Dr Mezey clearly did fail to deliver an adequate standard of care as the Francis panel found but was it “through”, i.e. caused by, lack of knowledge, ability or consistently poor performance? If not, to hold a capability hearing would be in breach of contract.

54. That the focus is on capability is reinforced by paragraph 9:

“The procedures set out below are designed to cover issues where a doctor’s or dentist’s *capability* to practise is in question.” (The emphasis is in the text of document itself.)

So the question here is whether Dr Mezey’s capability to practise is in question.

55. Thus it seems to me that in order invoke Part IV Dr Mezey must be shown to have lacked knowledge, or ability, or to have rendered consistently poor performance so as to have demonstrated that her capability to practise was in question. That is the threshold test.
56. The findings of the Francis panel preclude such a judgment being made against her. True it is that she was guilty of negligence in the *Bolam/Bolitho* sense. But her competence was established in paragraph 30 of the Report, [40] above, and she has insight and would now deal with this sort of case differently, see paragraph 32.2.4 at [40] above. Most importantly the conclusion of the Francis panel in 32.2.5 is worth repeating:

“Given that GM is an obviously conscientious and competent consultant psychiatrist *we do not regard her mistake* with regard to this decision, one which might well have been made by others, *indicates any cause for concern that she is likely to put other patients or the public at risk in the future* if she were to continue in forensic hospital practice, whether or not combined with academic duties”, with the emphasis added by me.

If, as Francis found, her decision to grant unescorted leave was inappropriate, nevertheless “it did not amount to serious professional incompetence”. In the light of those findings it seems to me that this is not a case “where there is genuinely serious misconduct” which permits a disciplinary hearing. Her capability to practice was not called in question by the Francis panel: on the contrary her competence was vindicated.

57. In my judgment the threshold for invoking any disciplinary procedure is not crossed and the Trust are not entitled to commence disciplinary action under Part IV.
58. The aim and purpose of Part IV is clear. The aim is to improve the quality of medical practice. Prevention is better than cure. Resort to the NCAA is mandatory for it is better than discipline except where there is a genuinely serious failure. There has been no resort to the NCAA here. Bearing in mind the regularly stated requirement that the case must first be referred to NCAA, paragraph 15 of Part IV says it all:

“The NCAA will assist the employer to draw up an action plan designed to enable the practitioner to remedy any lack of capability that has been identified during the assessment. The Trust must facilitate the agreed action plan (which has to be agreed by the Trust and the practitioner before it can be actioned). There may be occasions when a case has been

considered by the NCAA but the advice of its assessment panel is that the practitioner's performance is *so fundamentally flawed that no educational and/or organisational action has a realistic chance of success*. In these circumstances, the case manager must make a decision, based on the completed investigation report and informed by the NCAA advice, whether the case should be determined under the capability procedure. If so, a panel hearing will be necessary." (The emphasis is mine.)

59. Dr Mezey's performance was not so fundamentally flawed that she needs some educational and/or organisational action plan. In those circumstances a panel hearing is impermissible. To impose it is to act in breach of the agreed procedure. It is a breach of contract which can be restrained by injunction. Although I have arrived at my conclusion by a slightly different route, because that is the way the case has been argued here, the judge was right to grant the injunction. I would dismiss the appeal.

Lord Justice Wilson:

60. I agree with both judgments.

Lord Justice Toulson:

61. I also agree. Despite the mist shrouding the question how precisely MHPS became part of the contract governing any disciplinary proceedings by the Trust against Dr Mezey arising from her management of JB's case, it is common ground (as well as being prerequisite to the action which the Trust seeks to take) that it did become part of the contract.
62. There are therefore two key questions to be answered – 1) what is the contractual scope and purpose of MHPS Part IV ("Procedures for dealing with issues of capability") under which the Trust intends to proceed; 2) having regard to the proceedings to date and to the material which the Trust seeks to place before a capability panel, is its proposal to hold a capability hearing compatible with the scope and purpose of Part IV?
63. As to the first question, I agree with all that Ward LJ has said.
64. As to the second question, para 4 of Part IV requires that a matter must be referred to the NCAA for its advice before the matter can be considered by a capability panel (unless the practitioner refuses to have his or her case referred to the NCAA). The contractual purpose of referring the matter to the NCAA is to obtain its advice in coming to a decision whether the matter raises questions about the practitioner's capability as an individual, and it is described in para 6 of Part IV as having a key role in providing expert advice. We were told that in this case the Francis Report was treated as standing in place of advice from the NCAA. I can see the practical sense of that. Moreover, in the letter, dated 28 May 2008, in which the Trust's chief executive gave formal notice to Dr Mezey of his decision to hold a disciplinary hearing, he made it plain that no material other than the Francis Report would be before the panel. In those circumstances, and in the light of the detailed investigation and conclusions recorded in the Francis Report, including particularly paragraphs 30, 32.2.5 and 33, I

cannot see a basis for now proceeding to hold a capability hearing consistent with purpose of Part IV. As Ward LJ has succinctly put it in para 56: “Her capacity to practice was not called in question by the Francis panel; on the contrary her competence was vindicated”.