[2008] EWHC 3340 (QB)
IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION

Case No: 08IHQ0483

Royal Courts of Justice
Strand
London
WC2A 2LL

Date: Friday, 5th December 2008

Before:

MR JUSTICE UNDERHILL

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B E T W E E N:

GILLIAN CLARE MEZEY

-v-

SOUTH WEST LONDON and ST GEORGE'S MENTAL HEALTH NHS TRUST

- -

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MR J HENDY QC, appeared on behalf of the Claimant
MR M SUPPERSTONE QC, and MS L MILLIN appeared on behalf of The Defendants

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JUDGMENT

MR JUSTICE UNDERHILL:

INTRODUCTION

1. The claimant is a consultant psychiatrist employed by the defendant ("the Trust") at Springfield Hospital in Tooting. Among her patients was John Barrett, a paranoid schizophrenic with a history of violence. On 1st September 2004 Mr Barrett was re-admitted to hospital for assessment following concerns about a possible deterioration in his condition. The same afternoon, the claimant authorised the grant to Mr Barrett of

unescorted “ground leave” for a period of one hour: that meant that he was allowed unsupervised release into the grounds of the hospital. The claimant had not at that stage been able herself to examine Mr Barrett because she was on other duties elsewhere, and she acted on the basis of what she was told by her colleagues (though Mr Barrett had been her patient for some time and she was generally familiar with his condition). Mr Barrett took advantage of his ground leave to abscond, and the following day he killed a stranger, Denis Finnegan, in Richmond Park.

2. In August 2005 the Trust informed the claimant that it would be commencing disciplinary proceedings against her on the basis of alleged deficiencies in her care of Mr Barrett. Although various issues were raised, the focus inevitably was on the decision to allow Mr Barrett unescorted leave. There was initially some dispute about the form which those proceedings should take; but it was eventually agreed that they would be conducted in accordance with Annex B of Department of Health circular HC(90)9, which the claimant said was the applicable procedure in accordance with the terms of her contract of employment at the material time. The claimant agreed not to undertake clinical work pending the outcome of those proceedings. (The Trust in fact sought to suspend her from all her duties, but in earlier proceedings I granted an injunction preventing it from doing so. Permission to appeal against that decision was refused by the Court of Appeal: see [2007] IRLR 237).

3. An investigating panel consisting of Mr Robert Francis QC and two independent consultant psychiatrists was duly appointed in accordance with the procedure required by Annex B. The panel reported on 28th March 2008: I will refer to their report as ‘the Francis Report’. I shall have to give more details of their findings in due course. At this stage, I need only say that although they made some criticisms of the claimant they found that she had not been ‘at serious fault’ in any respect, and they found that her continuing employment by the Trust

gave rise to no cause for concern.

4. Following receipt of the panel's report, the claimant's solicitors, Messrs Radcliffes Le Brasseur ('RLB'), wrote to the Trust on 11th April 2008 seeking among other things formal confirmation that no further action, and specifically no disciplinary action, would be taken against the claimant and that arrangements would be made for her return to clinical duties. On 25th April the Trust's solicitors, Messrs Capsticks, replied that:

> 'The Trust has considered the report as a whole and having done so has decided that a hearing under the Trust's Disciplinary Procedure should take place and has also concluded that no meeting should therefore take place between the Trust and Dr Mezey and her representative. The Trust has not concluded that no disciplinary action needs to be taken but the Trust will be writing to Dr Mezey to confirm that a disciplinary hearing will take place.'

(The reference to the Trust's disciplinary procedure was to a form of procedure introduced in 2006, to which I will refer as 'the 2006 procedure'.)

5. RLB replied on 13th May 2008, protesting that disciplinary proceedings could not be pursued in the light of the panel's findings and asking the Trust to reconsider. Capsticks' answer dated 20th May, said that the Trust had indeed reconsidered but that it maintained its original decision. The letter concluded:

> 'It is not accepted that the Trust is bound by the views expressed in Part 2 of the Report that Dr Mezey was not at serious fault with regard to the matters that the Panel have found proved. However, even if, contrary to the Trust's view, the Trust is so bound, the findings of fact in Part 1 and the views expressed in Part 2 that Dr Mezey was at fault, but not at serious fault, would warrant the holding of a disciplinary hearing.
>
> 'The Trust has also given consideration to your request that Dr Mezey be allowed to return to her clinical duties as a Consultant Psychiatrist with the Trust. The Trust has decided in the light of the findings of fact made in Part 1 of the Report and having considered the Report as a whole, and having decided to proceed with a disciplinary hearing, that Dr Mezey should not return to her clinical duties before the conclusion of the disciplinary process.
>
> 'Arrangements will now be made for the disciplinary hearing to take place as soon as possible and the Trust will be writing shortly to Dr Mezey in this regard. The Trust's current Disciplinary Procedure will apply (in so far as it is

> relevant). The Chief Executive of the Trust will conduct the hearing and make the decision as to what, if any, disciplinary action should be taken.'

6. On 28th May 2008 Mr Peter Houghton, the Chief Executive of the Trust, wrote to the claimant giving her formal notice of his decision to set up a disciplinary hearing as already adumbrated in Capsticks' letter. The letter began:

> 'I have given careful consideration to the Report of the panel chaired by Robert Francis QC. In the light of the serious findings made against you I have decided to set up a disciplinary hearing to consider them further.'

Various details of the proposed hearing were then given, including a date of 9th June. It was made clear that no material other than the Francis Report would be before the hearing. The letter then continued:

> 'The panel will decide at the end of the hearing whether or not any disciplinary action, up to and including dismissal, should be taken against you.'

7. In those circumstances the claimant on 5th June 2008 issued the present proceedings, seeking principally an injunction prohibiting the Trust from holding a disciplinary hearing and from continuing to exclude her from clinical work. An application for interim relief was issued on the same day, returnable on 12th June.

8. That appears to have prompted a rethink on the part of the Trust. On 9th June 2008 Capsticks wrote as follows:

> 'Thank you for your letter of 5th June 2008 enclosing High Court Proceedings No. H008X02149.
>
> We are instructed to respond as follows.
>
> 1. The Trust agrees to lift Dr Mezey's suspension/exclusion from clinical work and Dr Nereli, Medical Director, will be contacting Dr Mezey by noon on Wednesday 11th June 2008 to discuss arrangements for her return to 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
…'

9. That letter reflected a change in the Trust's position in, so far as material to these proceedings, three respects.

10. First, contrary to the position taken in Capsticks' letter of 20th June 2008, the claimant was to be permitted to return to clinical duties in advance of any disciplinary hearing. She in fact did so shortly afterwards and has continued to work for the Trust up to the present day.

11. Secondly, although the Trust maintained its intention to conduct a disciplinary hearing, it now proposed to do so not under the 2006 procedure but under the procedure provided for in the Department of Health publication *Maintaining High Professional Standards* (that is the 'MHPS 2003/2005' referred to in the letter): for the genesis and status of this document, see paragraph 29 of my first judgment in the earlier proceedings. RLB had made the point in earlier correspondence that if, contrary to their primary case, there had to be a disciplinary hearing the provisions of MHPS should apply.

12. Thirdly, the Trust accepted, contrary to what Mr Houghton had said in his letter of 28th May 2008, that dismissal was not a potential outcome of the proposed disciplinary hearing.

13. Those concessions greatly reduced the ambit of the dispute between the parties. However, it remains the claimant's position that no disciplinary hearing of any kind should proceed. Whether that is correct is the principal issue before me, but there is also a question as to whether, if a disciplinary hearing should proceed, Mr Houghton should, as proposed, be a member of the disciplinary panel.

14. As a matter of form, those issues come before me on the basis of the claimant's original adjourned interim application dated 5th June 2008 (I have not sought to explore why it has taken so long for that application to be relisted); but the parties have agreed that the

application should be treated as the trial of the action.

15. Before me the claimant has been represented by Mr John Hendy QC, and the Trust by Mr Michael Supperstone QC, leading Ms Leslie Millin of Capsticks.

THE PROVISIONS OF HC(90)9

16. Annex B of HC(90)9 is headed 'Disciplinary proceedings in cases relating to hospital and community medical and dental staff and doctors in public health medicine and the community health service'. It sets out the form of disciplinary procedure to be followed in the case of what are described at paragraph one of Annex B as 'Serious disciplinary charges, for example where the outcome of disciplinary action could be dismissal.' It covers three categories of case, defined in paragraph 3 as: "(a) cases involving personal conduct; (b) cases involving professional conduct; and (c) cases involving professional competence". The case against the claimant was essentially of the third kind.

17. Annex B provides that where a *prima facie* case of professional incompetence is established 'which, if well-founded, could result in serious disciplinary action such as dismissal' (see paragraph 5) an independent investigating panel should be set up to conduct a factual inquiry. I need not set out the detailed provisions about the composition of the panel or how the inquiry should proceed, but I should read paragraphs 14 to 16 which are as follows:

> '14. The report of the investigating panel shall be presented in two 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 shall 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 a 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 the 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. It will be noted that paragraph 16 provides for what is in effect a hearing (although that term is not used) before a 'meeting of the authority' if, but only if, the investigating panel has made a finding that the practitioner was 'at fault' – the purpose of the hearing being to allow the practitioner to advance matters in mitigation before any decision is taken as to action. It was common ground before me that that hearing is properly to be characterised as a disciplinary hearing and any action taken pursuant to it as disciplinary action. Although that term is not used in paragraph 16 itself, the whole Annex B procedure is explicitly a disciplinary procedure (and see also the references to 'disciplinary action' in paragraph 14).

19. I should also refer to Annex E to HC(90)9. This sets up a so-called 'intermediate procedure', described in the introduction to the circular as 'a new procedure for dealing with cases of professional misconduct and professional incompetence which warrant disciplinary action short of dismissal'. Annex E provides for an investigation by assessors who are to report to the appropriate authority which will then take any disciplinary action - 'e.g. a warning' that might be appropriate.

THE FRANCIS REPORT

20. Paragraph 1.1 of the Francis Report sets out the panel's terms of reference as follows:

'This panel of inquiry was appointed by the South West London and St George's Mental Health NHS Trust [the Trust] under the terms of circular HC(90)9 to report on allegations against its employee, GM, contained in the following terms of reference.

1. To consider the appropriateness of the decision by GM to admit Mr Barrett on 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 1 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 10 October 2003 and 1 September 2004 was appropriate.'

'GM' is of course a reference to the claimant.

21. Paragraph 1.2 sets out particulars of the allegations made against the claimant as regards element 3 in the terms of reference as follows:

'Particulars of paragraph 3 of the Terms of Reference were given subsequently by the Trust:

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 mental 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 case and treatment of Mr Barrett, changes in his mental state and level of risk was irregular and inadequate.'

22. The Trust in the present case did not take up the option provided for at paragraph 14 of Annex B of inviting the panel to make recommendations as to disciplinary action.

23. Paragraph 6 of the Francis Report is headed 'Standard of practice applied in this report'. At

paragraphs 6.1 and 6.2 the panel said this:

> '6.1. The Terms of Reference invite us to make findings as to whether the decisions and management of JB by GM was "appropriate" in various respects. It is necessary to define what we understand this term to mean in this context.
>
> 6.2. Clearly the allegations made against GM that her decisions and managements were *in*appropriate implies the assertion that GM fell below the relevant professional standard in these respects.'

They then went on to record that they had been asked by the Trust, with no dissent on behalf of the claimant, to apply the so-called *Bolam/Bolitho* test as developed in clinical negligence cases: the reference is of course to the well-known decisions of McNair J. in the *Bolam* case [1957] 1 WLR 583 and of the House of Lords in *Bolitho v City and Hackney Health Authority* [1998] AC 232. They set out a long passage from the speech of Lord Browne-Wilkinson in *Bolitho* and concluded as follows:

> 'The panel has been mindful of these principles and applied them in this case. 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 standard 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 rarely fall into such a category.'

24. As required by paragraph 14 of Annex B, the substance of the report was in two parts.

25. Part 1 contains a careful and thorough consideration of the issues raised by the terms of reference and extensive findings of primary fact. It also makes findings as to whether or not in the relevant respects the claimant had fallen below the standard of professional competence in accordance with the *Bolam/Bolitho* test. In most respects, it dismisses the allegations against her. However, there are two areas of criticism:

> (1) The panel found, as summarised at paragraph 14.12, 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

> supervisors' reports were submitted to the Home Office when required but that this failure was contributed to by the relevant specialist registrar and by the Home Office itself. We accept that it was commonplace in forensic services generally at the time for reports on restricted patients to be late or not sent at all.'

That criticism is not negligible but nor is it on any view very grave, and it is not suggested that it had any impact on the tragic outcome in Mr Barrett's case. In view of the more significant criticism which I am about to come to, it was not focused on in the submissions before me and I need say no more about it.

(2) More significantly, the panel were critical of the decision by the claimant to allow Mr Barrett unescorted leave. The factual and expert issues which they had to review were complex, and I need not for the purpose of this judgment consider them. In short, the panel found that the claimant's decision was one which other competent practitioners might have made, and so satisfied the basic '*Bolam* test'; but they went on to conclude that this was one of those comparatively rare cases where the decision was nevertheless not supportable in the sense explained in *Bolitho*. The essence of the decision appears at paragraphs 27.20-23, which read as follows.

> '27.20 In coming to this conclusion, adverse as it is to the case put to us on behalf of GM, we take into account, and will do so again when considering what, if any, fault attaches to her, the following matters relevant to the standard of practice:
>
> > 27.20.1 She could reasonably have expected any obvious signs of deterioration or increase in risk to be detected by ward staff and to have led to a refusal of leave.
> >
> > 27.20.2 It was not due to any breach of duty on her part that she was not available in the hospital on 1st September to undertake a personal assessment of JB.
> >
> > 27.20.3 There do not appear to have been any clear arrangements available for the provision of consultant cover in the circumstances of this case.

27.20.4 We accept that GM could not have been reasonably expected to foresee that neither she nor Ms Sturdy would be informed of JB's absconsion for some 17 hours after he failed to return.

27.20.5 She could reasonably have expected that steps to initiate a Home Office recall or other form of compulsory detention would have been taken within a very short period following JB's failure to return.

27.20.6 She could reasonably have expected that all practicable steps to trace JB, including obtaining the co-operation of the police, would have been taken within a very few hours of his failure to return.

27.21 We also take into account the fact that GM was a highly experienced and distinguished practitioner as described above. Naturally this has encouraged the panel to approach the criticisms made of her on behalf of the Trust with considerable caution.

27.22 In spite of these points, and 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. JB had previously committed acts of violence when unwell. He had been in the ward for a very short time before he was let out again and therefore without any opportunity for sustained observation. It is to be noted that Dr Anakwue considered that observations every five minutes were required. There had therefore been insufficient assessment of whether the signs of deterioration represented a serious relapse and increase in the level of risk. We are, of course, unable to speculate on what might have been the result of an assessment by GM and whether leave would or would not properly have been granted after it.

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

There are inevitably one or two factual aspects of that passage which will not be clear without a more detailed exposition of the background, but I quote it simply in order to summarise the decision and the particular details of the reasoning are not material for present purposes.

26. At paragraph 28 of the report, being the final paragraph of Part 1, the panel gave a helpful summary of their findings in the following terms:

'28. Summary.

For the reasons given above we find:

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 supervisors' 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.'

27. Part 2 of the Francis Report reads as follows:

'29. Findings of fault

We understand that the task of the panel is to indicate the extent to which, if at all, the findings of fact we have made amount to evidence of serious professional incompetence or misconduct. The Trust has alleged that the failure to comply with Home Office guidelines in relation to reporting may be a matter of misconduct or competence. The criticism with regard to unescorted leave is, the Trust argues, one of competence.

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. This report does not recite from that body of evidence, but should be read as incorporating it. 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 bullet point
- An ability to listen to the views of others
- Her success as a manager of services bullet point
- 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 her profession.

31. Reporting.

31.1 We have found that GM failed to comply with the standards of good practice and the requirements of the Home Office rules in not making reports to the Home Office on the occasions identified in part one above. We have also found that this omission was contributed by the SpR and the Home Office.

31.2 We note that the Home Office has not expressed concerns about any non-compliance. We are aware that practice may have been tightened up as a result of this case, but we accept that at the time in question it was not uncommon for the guidance not to be followed strictly.

31.3 It is also relevant that reports were being sent by Ms Sturdy. While we have accepted that reports from the supervising psychiatrist might have brought an additional dimension to the knowledge and information available to the Home Office, we are not satisfied that any important matter was not effectively brought to their attention in this case. We think it is highly unlikely that the omission to file reports in itself would have led to any suggestion of a disciplinary process in this case had it not been for the tragedy that occurred following the grant of unescorted leave, a matter we consider to be totally unconnected with the absence of reports at prescribed intervals.

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 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 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 and respect 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.

32.2.3 GM was undoubtedly at a disadvantage in having to make decisions about this patient when absent from the 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 learned 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 did 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 were she 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 concerns.

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 PROCEDURE UNDER MHPS

28. As noted above, the Trust in its solicitors' letter of 9th June 2008 agreed that the disciplinary hearing which it proposed to hold would be in accordance with the provisions of MHPS. Sections III and IV of MHPS contain an entirely new form of procedure for dealing with cases of misconduct and professional incompetence in substitution for HC(90)9. Section III is headed 'Guidance on conduct hearings and disciplinary proceedings'. Section IV is headed 'Procedures for dealing with issues of capability'. (It is to be noted that the term 'disciplinary' does not appear in the title of section IV; nor, to anticipate, does it appear in the text.) Under the section IV procedure, there is no wholly independent investigatory panel of the kind provided for under HC(90)9. Rather, where the case is not judged appropriate to be dealt with by a referral to the National Clinical Assessment Service or other informal means, a 'capability hearing' will be held before a panel of three, comprising an Executive Director of the Trust as chairman,

together with another senior Trust employee and a doctor not employed by the Trust. That panel will both investigate the facts and decide on the outcome.

29. Paragraph 24 of section IV of MHPS is headed 'Decisions' and begins as follows:

> 'The panel will have the power to make a range of decisions, including the following:'

There then follows a box with the title 'Possible decisions made by the capability panel', containing five bullet points as follows:

- No action required.
- Oral agreement that there must be an improvement in clinical performance within a specified timescale 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 timescale with a statement of what is required and how it might be achieved (stays on employee's record for one year).
- 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.

30. Clause 17 of a 'new consultant contract,' signed by the claimant on 18th March 2005 provides, under the heading 'Disciplinary matters', that:

> 'Wherever possible, any issues relating to conduct, competence and behaviour should be identified and resolved without recourse to formal procedures. However, 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 procedure (which will be consistent with the *Maintaining High Professional Standards in the Modern NHS* framework) subject to the appeal arrangements set out in those procedures.'

As I understand it, the parties eventually agreed that that provision - and, accordingly, the requirement to operate a procedure 'consistent with' MHPS - does not directly bite on the proceedings in the present case: that is why the procedure under HC(90)9 was followed. But it was, and is, the claimant's case that the MHPS procedures nevertheless applied indirectly, on the basis of the argument which I summarised in paragraphs 16 and 18 of my judgment in the earlier proceedings (or some analogy to it). That contention has, in practice

if not in form, been accepted by the Trust's agreement that any remaining stages of the disciplinary procedure should be in accordance with section IV of MHPS.

31. That means that the procedure now intended to be followed by the Trust is something of a hybrid. The fact-finding role has already been performed by the investigating panel chaired by Mr Francis in accordance with HC(90)9; and the Trust has confirmed that it will not take into account any other matters beyond the contents of the Francis Report and any representations to be made by the claimant by way of mitigation. But the question of what, if any, action should be taken on that basis will be considered in accordance with the provisions of MHPS. The Trust's proposal is that the panel constituted for that purpose should be chaired by Mr Houghton. The other members would be Dr Nereli and Dr Larkin, who is the Assistant Medical Director at Rampton Hospital. The hearing was to have been held on 10th November, but it was postponed when it was clear that the present application was being proceeded with.

THE ISSUES

32. The claimant's primary case is that the finding of the Francis Report that there had been no serious fault on her part, coupled if necessary with the finding that there was no cause for concern about her competence, means that the Trust is not contractually entitled to proceed with a disciplinary hearing. As I have said, there is a secondary submission that if, contrary to that contention, the Trust is entitled to hold a hearing Mr Houghton should not be a member of the panel. I will consider those issues in turn.

IS THE TRUST ENTITLED TO HOLD A DISCIPLINARY HEARING?

33. Mr Hendy puts his case in two ways. First, he submits that it is clear from paragraph 16 of Annex B that a disciplinary hearing can only proceed if the investigating panel has made a finding of fault; and, he submits, it has not done so. Secondly, he submits that even if in principle such a hearing could proceed, there is in the light of the panel's findings no

disciplinary action which it could properly take, and that accordingly the decision to hold such a hearing is irrational and outside the Trust's contractual rights.

34. As to the first point, Mr Hendy is in my view plainly right that the Trust can only proceed to a disciplinary hearing where there has been a finding of fault by the investigating panel. That seems to me necessarily to follow from the second sentence of paragraph 16: it is inconceivable that a disciplinary hearing could continue without the practitioner being given notice of the findings of the report and an opportunity to make representations, but those steps are only provided for where there has been a finding of fault. My attention was drawn to the judgment of Eady J in *Mattu v University Hospitals Coventry and Warwickshire NHS Trust* [2006] EWHC 1774 (QB), in which he left open the possibility that, in a procedure substantially identical to HC(90)9, a finding of fault might not be a necessary requirement for the initiation of a disciplinary hearing: see paragraph 92(3). But in my view, having heard argument on the point and considered carefully the wording of Annex B, that does not seem to me to be a possible reading. I note in any event that Eady J. said that such a case was difficult to imagine and would occur rarely if at all.

35. The question therefore is whether the panel did indeed make a finding of fault. The issue was canvassed before me of whether any such finding has to be looked for either only in part 1 of the report or only in part 2. The word 'finding' would, if taken by itself, point to part 1, because that is supposed to contain the panel's 'findings' as opposed to its 'views', which are to be expressed in part 2. On the other hand, questions of 'fault' are supposed to be covered in part 2. In my view the drafting of Annex B is not sufficiently tight to justify that level of strict verbal analysis. The natural construction of paragraph 16, despite the use of the word 'finding', is that the reference is to the 'views' about fault which the panel will have expressed in part 2 and that the terms 'findings' and 'views' are, in this context at least, interchangeable. I note that that seems to have been the panel's understanding since

their conclusions in part 2 were expressed as findings, not views.

36. Taking that approach, there is in fact no explicit finding, or view, in part 2 of the report that the claimant was 'at fault'; but the Trust contends that the panel's finding that the claimant was 'not at serious fault' necessarily implies that she was at fault to some degree, and it is legitimate to refer to part 1 to identify the fault so found, namely the 'inappropriate decision to allow Mr Barrett unescorted leave' referred to at paragraph 27.23. The rather anodyne adjective 'inappropriate' was forced on the panel by the language of the terms of reference, but, as they explain at paragraph 6 of the report, it connotes a failure to act in accordance with a proper professional standard, applying the *Bolam/Bolitho* test.

37. Mr Hendy's submission in response is that, whether or not the claimant was at fault in that 'non-serious' sense, 'fault' in paragraphs 14 and 16 of Annex B has a more limited meaning and refers only to 'serious professional incompetence' as defined in paragraph 1 - that is to say, incompetence of such a degree that the outcome could be dismissal. Only *serious* professional incompetence, he points out, comes within the scope of Annex B, and that was thus necessarily what the claimant was charged with. It is for that reason, he submits, that the panel in their findings in part 2 use the language of 'serious' fault: that was a shorthand for 'fault of sufficient seriousness to engage disciplinary action under Annex B'. If that submission is right, then there is plainly no finding of fault sufficient to trigger any further disciplinary step under paragraph 16.

38. I was initially attracted by that submission, but on balance I think it is wrong. Unless there were anything in the context which clearly limited its meaning, the term 'fault' in paragraph 16 would naturally cover fault of any degree. I do not think that it follows from the fact that Annex B will only be employed where charges are 'serious' that the Trust has no power under its provisions to take disciplinary action unless such charges are proved. There will sometimes be cases - and the Trust would say that the present case was a good example -

where a practitioner is acquitted on the serious charges which justified the original employment of Annex B but the panel nevertheless makes findings of fault of a lesser character which do not satisfy the definition of seriousness in paragraph 1 but which might nevertheless justify disciplinary action short of dismissal. There is no reason in principle why a trust should not proceed to take disciplinary action in respect of any faults so found, if it were otherwise appropriate to do so; and it is plainly convenient that it should be able to do so in the context of the proceedings already brought rather than having to resort to the provisions of Annex E or any other contractual procedure that might be available.

39. I accordingly reject Mr Hendy's submission on this point: the fact that the panel rejected the charges of serious professional incompetence against the claimant does not by itself mean that the Trust cannot assert that they made a finding of fault within the meaning of paragraph 16. On that basis there is obviously commonsense force in the Trust's contention that the criticisms identified plainly amounted to findings of fault, albeit 'non-serious' fault; and I will for the present proceed on that basis - although, as will appear, the position may not be quite so straightforward.

40. I turn therefore to Mr Hendy's second submission, namely that in the particular circumstances of the present case no disciplinary action could properly follow from the findings made in the Francis Report; and that there is thus no purpose in a hearing. He refers to the options set out at paragraph 24 of section IV of MHPS and submits that none of them save ('no action required') is even arguably appropriate. 'Termination of contract' has of course already been ruled out. The remaining three options, which are in effect all forms of warning that an improvement in clinical performance is required, are ruled out by the panel's finding that the claimant was and remains 'an obviously conscientious and competent consultant psychiatrist', who has learned such lessons as are to be learned from what happened in Mr Barrett's case and in respect of whom that there was no cause for

concern. Those findings were, he submitted, binding on the Trust. But it has in any event accepted them by deciding to allow her unconditional return to full-time clinical duties: Mr Houghton and Dr Nereli in their witness statements lodged for the purpose of these proceedings both say in terms that they took that decision on the basis of the panel's findings that the claimant was not seriously at fault and that their findings gave rise to no cause for concern about her competence.

41. I agree with that submission. It seems to me that 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 made no positive case to the contrary, limiting himself to the submission that all options (save dismissal) were open. However, the options specified in paragraph 24 are not expressed to be exhaustive. They are introduced by the phrase 'a range of decisions, *including* the following'. The real question is whether it is open to the Trust, either in principle or on the facts of this case, to take some other form of disciplinary action, i.e. beyond those specified.

42. I am bound to say that I would have expected the Trust, in taking the decision to proceed with a disciplinary hearing, to have given some thought to the question of what the potential outcomes might be, particularly after it had ruled out dismissal; but there is no evidence that it has done so. I was told that, somewhat surprisingly, neither the original decision to proceed with a hearing or the two subsequent occasions on which, according to the evidence, that decision was reviewed generated documentation of any kind. Mr Houghton's witness statement goes no further than expressing the view that it was necessary to hold a hearing in the light of the panel's criticisms of the claimant. Similarly, neither the Trust's solicitors' correspondence or Mr Supperstone's skeleton argument addresses the question of what sanctions might be available in the case of a resumed hearing or what, therefore, the purpose of such a hearing was. It would of course have been wrong for the Trust to

prejudge the outcome of the hearing in any way, but a consideration of the available options would not have constituted any kind of pre-judgment and would have been positively helpful to me in understanding the purpose of the proposed hearing.

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. Such reprimands or admonitions are not uncommonly provided for in the disciplinary codes promulgated by professional bodies, though I cannot recall having seen them provided for in a contractual disciplinary procedure applying to employees. 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. It may be debatable to what extent it differs from a pure 'warning' - that is to say, a warning that does not specify any consequences attendant on repetition of the act or omission in question. Warning is itself a term with different shades of meaning, perhaps illustrated by the fact that the verb *monire* which forms the root of the word 'admonish' may be translated equally as 'to warn' or 'to advise'.

44. Mr Supperstone adopted in his oral submissions the suggestion that it would be open to the Trust on a disciplinary hearing to impose a reprimand of this character. Mr Hendy, however, rejected it. His first objection was that the Trust had, as I have already noted, never suggested that its reason for proceeding was in order to impose any sanction of this character. I do not think that that by itself means that it cannot rely on that possibility now that it has been raised. The real question must be what its powers were, not whether it had in advance of these proceedings understood them correctly. Nor do I think that it is decisive

that no power to administer a reprimand is expressly provided for in MHPS in a case where the contractual procedures do not purport to spell out exhaustively the available disciplinary sanctions: there is no reason in principle why a power to administer a formal reprimand should not be implied.

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 claim not to have made such misjudgements occasionally.

46. There may be room for debate at the general level about exactly what the purpose is of imposing disciplinary sanctions short of dismissal. Paragraph 58 of the ACAS *Code of Practice on Disciplinary and Grievance Procedures* states that:

> 'Disciplinary procedures should not be seen primarily as a means of imposing sanctions but rather as a way of encouraging improvement among employees whose conduct or performance is unsatisfactory.'

On the facts of the present case there could be no suggestion that a reprimand is necessary or appropriate as a way of encouraging improvement. No doubt in some circumstances a reprimand may be justifiable on some other basis beyond that suggested by ACAS; but I

cannot see what that basis would be here. I do not believe that in the medical profession 'pure misjudgements of the kind with which we are concerned here would ordinarily be understood to attract disciplinary penalties of any kind, even at the low level of a reprimand (and even though they might, if damage was suffered, render the practitioner liable in negligence). That understanding may be reflected in the deliberate avoidance of the language of 'discipline' in part IV of MHPS and may explain why the admittedly non-inclusive list of 'possible decisions' in paragraph 24 focuses entirely (except at the two extremes) on steps aimed at procuring improvements in clinical performance. It may also explain why the Trust itself has not suggested a reprimand as a possible outcome until the course of this hearing. It is relevant too to refer to the terms of paragraph 17 of the new consultant contract, even if that is not formally applicable on the facts of the present case: it will be recalled that that provided that 'our disciplinary or capability procedure' would only be used where 'your professional competence has been called into question'.

47. In short, I do not believe that the findings made by the panel in this case are capable of justifying disciplinary action.

48. It would be possible to reach the same conclusion by holding that the panel's criticisms of the claimant cannot in fact be characterised as findings of 'fault'. As I have already noted, the panel itself never used that term; and although I see the force of the Trust's contention that the finding that the claimant was not 'at serious fault' implies a finding of non-serious fault I do not think that that is necessarily correct - the use of the term 'serious' may be explicable on the basis that the panel understood that that was the essential criterion which they were required to apply. I note that the panel elsewhere contemplated that their criticisms did not necessarily involve any findings of fault - see the phrase 'if any' in paragraph 27.20. However, I prefer not to base my decision on this ground, mainly because it puts the focus on verbal riddles of the kind of 'when is a mistake not a fault?' rather than

on the substantive question of what kind of mistake may properly be the subject of a disciplinary sanction. It also enables me to avoid the question raised by Capsticks' letter of 20th May 2008 of the extent to which an authority is bound by a panel's findings or views on the issue of fault as expressed in part 2 of the report. I do not find that question entirely straightforward; but it does not arise in the present case because there is no realistic prospect that the Trust could justify revisiting the panel's conclusion that the claimant was not guilty of serious fault, not least in the light of Mr Houghton's and Dr Nereli's reliance on that conclusion to justify allowing the claimant to return to work.

49. I accordingly believe that it would not be open to the Trust on the basis of the Francis Report to impose any disciplinary sanction on the claimant. That does not mean that the Trust may not hold a meeting in order to reach a formal decision on what action to take (in practice no action, or at any rate no disciplinary action), as indeed is required by the first sentence of paragraph 16 of Annex B. But it does mean that there is no basis for a hearing of the kind provided for in the second sentence of paragraph 16. Since the Trust plainly proposes, unless restrained by injunction, to conduct such a hearing, the claimant is entitled to relief prohibiting it from doing so. I will hear submissions, if necessary, on the precise form of any such relief.

50. It should not be thought that the effect of my decision on this issue is in any way to belittle the tragedy which befell Denis Finnegan and his family or to ignore the fact that the claimant made a misjudgement which had shocking consequences. I am told that the claimant has consistently expressed her distress and regret at what occurred, and that was repeated through her counsel before me. But by the very nature of their work the misjudgements which doctors, like everyone else, sometimes make are liable to have very serious consequences. It does not follow that every such mistake or misjudgement deserves disciplinary action - or, in case this be suggested although I should make it clear that there is

no evidence that it informed the Trust's thinking - that disciplinary action has to be taken in a high-profile case in order to show that the Trust is taking matters seriously. What is required in every such case is a careful examination of the misjudgement in question, including an assessment of whether it reflects on the doctor's overall capability. Such an examination has occurred in this case, using the very thorough HC(90)9 procedure, and the outcome of the inquiry must be respected.

SHOULD MR HOUGHTON BE ON THE PANEL?

51. In view of my decision on the previous issue this question does not arise, but I will nevertheless deal with it briefly. As I have recounted, Mr Houghton in his letter of 20th June 2008 described the Francis Report as having made 'serious findings' against the claimant and went on to say that the panel which he was to chair would decide 'whether or not any disciplinary action, *up to and including dismissal*, should be taken against you'. As recognised by the Trust's subsequent change of position, that is a letter which should not have been written. Dismissal was not a possible disciplinary sanction in the light of the Francis Report. Further, although in a different context the description of the panel's criticisms of the claimant as 'serious' could perhaps be defended, it was quite inappropriate terminology where the panel had expressly rejected the charge of serious professional misconduct.

52. It was suggested to me that the reference to a potential dismissal merely reflected the panel's formal powers and that, even if dismissal was not in fact a possible sanction in the light of the report, it was premature to reach a formal conclusion to that effect until the hearing had taken place. That betrays a real insensitivity to the human position. It is not difficult to imagine the dismay felt by the claimant, having after four years been exonerated from the serious charges against her, to be told not only that she could not return to work pending disciplinary proceedings but also that she still faced the possibility of being

dismissed. It is, I think, a pity that the proper consideration which the Trust did eventually give to the real implications of the Francis Report once the claimant issued proceedings did not occur many weeks earlier.

53. In those circumstances I think that there would be room for legitimate concern that Mr Houghton, having committed himself firmly on paper to an erroneous view of the effect of the Francis Report, would find it difficult to approach the question of any disciplinary action on a basis which fairly reflected the real findings of the investigating panel. It is relevant to observe in this connection that the letter was in no sense out of context. As I have already noted, according to the correspondence and his witness statement Mr Houghton had already had occasion to consider the effect of the report on two previous occasions.

54. I do not wish to be unfair to Mr Houghton personally. The claimant requested his attendance for cross-examination at the hearing but did not in the event choose to cross-examine him. In these circumstances I could not and do not make any finding of actual bias. It may be that Mr Houghton was not the draftsman of the letter in question and was let down by his advisers: I note that he wrote a much more sensitively-worded letter at the time of the Trust's original attempt to suspend the claimant. Nevertheless, the claimant is entitled to judge him by the letter that he sent, and in my judgment there is a sufficient case here of 'apparent bias' to have made it inappropriate for Mr Houghton to sit on the disciplinary panel had the matter proceeded.

MR SUPPERSTONE: My Lord, can I just rise first just on one factual matter?

MR JUSTICE UNDERHILL: Yes. There is always an invitation to counsel to correct me on factual matters but particularly in this case where there is quite a lot of detail and I might have got details wrong.

MR SUPPERSTONE: My Lord, I'm grateful. Can I just be permitted to attempt to do so? My

Lord said that you took me as accepting that warnings of the type contemplated in paragraph 24 of MHPS would not be justified. My Lord actually raised that matter expressly with me during the course of submissions and put that to me as your understanding and my response was that it was my submission that all options, less the dismissal, were open under paragraph 24.

MR JUSTICE UNDERHILL: Well, I was anxious not to misquote you: I did actually have a note against paragraph 24: 'MS. I accept that these kinds of warnings are inappropriate but a reprimand or admonition might be and could be disciplinary.' However, the short answer to this is, if I look at my note, I did not simply decide it on the basis of what I thought was your concession. I said in terms that I agreed with Mr Hendy's submission. I think, rather than have an undignified spat about whatever you said, I will take out that passage and put it entirely on my own judgment.

MR SUPPERSTONE: My Lord, I'm grateful. If My Lord had that noted then...

MR JUSTICE UNDERHILL: I did have that noted so it must reflect something, but I am very willing to believe, argument goes to and fro, that I might have taken it out of context in some way or we may have been at cross-purposes.

MR SUPPERSTONE: My Lord, I'm grateful.

MR JUSTICE UNDERHILL: Yes. Any other points on the judgment?

MR HENDY: Only a tiny one, My Lord. The reference for *Mattu* is page 237 in IRLR. I think Your Lordship said 337. Trifling.

MR JUSTICE UNDERHILL: Well, it cannot be *Mattu* because it is unreported.

MR HENDY: The other case, sorry.

MR JUSTICE UNDERHILL: Not this... This very case, the earlier stages?

MR HENDY: Yes, this very case.

MR JUSTICE UNDERHILL: Well, thank you. I imagine if a transcript is bespoken that this bit

will get transcribed as well.

MR HENDY: Yes.

MR JUSTICE UNDERHILL: And I will pick that point up and put it into the corrected version.

MR HENDY: My Lord, as to other matters, I wonder if we could just have five minutes and return before Your Lordship just to see whether we are in position to deal with everything else today or not.

MR JUSTICE UNDERHILL: Well, I think that would certainly be sensible. I will give you within reason as long as you like as I will just go back to my room and get on with something else.

MR HENDY: Well, My Lord, I think just a short time to see whether we can accommodate everything now. If not, perhaps we will...

MR JUSTICE UNDERHILL: Yes, I would strongly encourage you to do so because, as I understand it, without putting words into anyone's month, there I think can only be two issues. One would be costs which I suspect will be straightforward and the other is the form of the order. It should not be too difficult to formulate something which basically simply says no disciplinary procedure should continue.

MR SUPPERSTONE: My Lord, I would have thought we would only need five minutes but, like Mr Hendy, I agree if My Lord would give us five minutes it may be very helpful.

MR JUSTICE UNDERHILL: There is an increasing culture (which I sometimes encourage) of subsequent written submissions. They just involve much more time and expense for everyone. I think we should knock it on the head if we can do it now.

MR SUPPERSTONE: Certainly.

MR JUSTICE UNDERHILL: Right.
