Neutral Citation Number: **[2021] EWHC 2811 (QB)**

Case No: H90MA099

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

Manchester Civil Justice Centre

Date: 22 October 2021

Before :

MR JUSTICE SOOLE

- -

Between :

MR VADERBETTU VIJAY KAMATH	**Claimant**
- and –	
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	**Defendant**

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Eleena Misra and **Adam Ross** (instructed by **Medical Defence Shield**) for the Claimant
Simon Gorton QC (instructed by **Weightmans LLP**) for the Defendant

Hearing dates: 28 June-1 July; 26-27 July 2021

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Judgment Approved by the court for handing down (subject to editorial corrections)

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Mr Justice Soole:

1. The Claimant is a Consultant Orthopaedic Surgeon who has been employed by the Defendant Trust since February 2010. On 20 November 2019 he was excluded, initially for four weeks, from all clinical and non-clinical work pending an investigation into his care of three patients (A, B and C) in the period Saturday 26 to Monday 28 October 2019. Following the investigation the Defendant decided that the matter must proceed to a disciplinary hearing into allegations of gross misconduct. Pending that hearing, but interspersed with periods of ill-health, the Claimant's exclusion has been repeatedly renewed. By this action the Claimant alleges that the Defendant has in various ways acted in breach of contract in its investigation and decision and seeks relief by way of declaration and final injunctions; and in particular to restrain it from proceeding with the disciplinary process and from his continued exclusion.

2. By interlocutory Order dated 15 March 2021, and upon the Defendant undertaking not to proceed with a disciplinary hearing in the meantime, HHJ Sarah Richardson, sitting as a deputy High Court Judge, ordered an expedited trial of the action.

3. As pleaded, the claim includes allegations of bias (actual or apparent) and of bad faith on the part of the Defendant's Case Manager Dr Grahame Goode : see in particular POC para. 50(3) and Reply para.15. In opening, Ms Misra maintained the case of apparent bias. No allegations of bias or bad faith were put to Dr Goode in cross-examination; and that case (including apparent bias) was properly withdrawn at the outset of Ms Misra's closing submissions.

Outline

4. The Claimant has been employed by the Defendant since February 2010 and ordinarily works at its Blackpool Victoria hospital. He was the Head of the Trauma and Orthopaedics Department ('the Department') from November 2011 until January 2017, but had taken a sabbatical from that role in November 2015.

5. There have been long-standing, major and unresolved inter-personal issues within the Department, which included mutual complaints made between the Claimant and some of his colleagues. Following a complaint of bullying against the Claimant in January 2017 the Claimant accepted a written warning and stepped down as Head of Department. The Defendant has taken steps to consider the dysfunctionality of working relationships within the Department, including the commissioning of a Team Review of the Department by the NHS agency Practitioner Performance Advice (PPA) which prepared a confidential report (not seen by the Claimant) dated 9 July 2019.

6. The Claimant is employed pursuant to a standard contract of employment which contains nationally agreed terms and conditions of service for NHS Consultants. Clause 17 provides that any issues relating to his conduct, competence or behaviour will be resolved in accordance with the Defendant's disciplinary and capability procedures which will be consistent with the Maintaining High Professional Standards in the Modern NHS ('MHPS') framework.

7. The Defendant's policy and procedure entitled 'Handling Concerns Procedure for Medical and Dental Staff' ('HCP') seeks to give effect to the MHPS. It is agreed that HCP is incorporated by reference into the Claimant's contract; and provides that in the event of any conflict or lack of clarity, MHPS takes precedence over the HCP.

8. The Claimant agreed to provide weekend on-call cover for another Consultant Orthopaedic Surgeon who wanted to take leave from Friday 25 to Monday 28 October 2019, with the on-call ending at 0800 on 28 October ('the October weekend'). He was rostered to work on that Monday (28) before departing the following day for authorised leave in India, returning to the UK on 16 November 2019.

9. Following his return, the Defendant's interim Medical Director, Dr Grahame Goode, on 20 November advised the Claimant that he was being investigated pursuant to the MHPS/HCP in connection with the care of three patients (A, B and C) who had been emergency admissions over the October weekend; and that pending investigation he would be excluded from all clinical and non-clinical work for four weeks.

10. For the purpose of these procedures Dr Goode was the appointed 'Case Manager' and Mrs Gillian Rose, a retired physiotherapist who did not work for the Defendant, was in due course appointed the 'Case Investigator'.

11. Patient A was a 15 year old girl, admitted late on Saturday night (26 October) with a complex ankle injury. Her operation did not take place until the afternoon of Monday 28, performed by Mr Anoop Anand, Locum Consultant Orthopaedic Surgeon. Patient B was a man aged 88, admitted at 12.35 on 27 October with various comorbidities and what transpired to be a septic knee, and who later died. Patient C was a man admitted on the late evening of 27 October with a complex open humeral fracture. Surgery did not take place until Thursday 31 October, performed by Mr Vishwanath Shetty, Consultant Orthopaedic Surgeon.

12. Mrs Rose carried out her investigation pursuant to Terms of Reference provided by Dr Goode and produced her Investigation Report dated 13 February 2020. Following its receipt and review, Dr Goode decided that the matter must proceed to a disciplinary hearing on the grounds of alleged (gross) misconduct by the Claimant. The Claimant was so notified by letter dated 24 February 2020.

13. Until April 2020 the Claimant was represented by the Medical Defence Union (MDU) and the British Medical Association (BMA) who were involved in without prejudice negotiations for the consensual termination of his employment, for which there has been a partial waiver of privilege. The negotiations were inconclusive.

14. On 8 April 2020 the Claimant was signed off work on grounds of ill-health and in consequence the disciplinary hearing fixed for 23 April 2020 did not take place. He subsequently instructed his present solicitors Medical Defence Shield (MDS). By letter to the Defendant dated 31 July 2020 MDS raised a number of concerns about the alleged misuse of the relevant procedures; including that it had wrongly categorised the concerns as raising issues of conduct (HCP Part 4) rather than capability (Part 5); and in consequence had wrongly instituted disciplinary proceedings.

15. By response dated 12 August 2020 the Defendant rejected these objections and in particular stated that the allegations related to the Claimant's *'conduct and probity'*.

The Claimant contends, and the Defendant disputes, that this was the first time that issues of probity had been raised with him.

16. By letter to the Defendant dated 25 August 2020 the Claimant raised a grievance which included the issue of categorisation. The Defendant declined to hear it as a grievance.

17. By 'Letter before Claim' dated 22 September 2020 MDS made complaints which included that Mr Anand had not been interviewed; that Mrs Rose had wrongly failed to obtain appropriate (i.e. orthopaedic) clinical input for her investigation; and that there had been no reference to probity concerns until the Defendant's letter of 12 August 2020. It invited the Defendant to reconsider the categorisation of the concerns; to undertake to carry out the hearing in line within the HCP Part 5 capability procedure; and to reconsider the Claimant's exclusion with a view to allowing him to undertake non-clinical work.

18. In consequence of that letter Dr Goode reconsidered his decision; and for that purpose obtained and considered further information which had not been before Mrs Rose; including from Mr Anand and Dr Saleem (Registrar). By letter dated 23 November 2020 he reaffirmed his decision on categorisation; and rejected the suggestion that probity had not been raised before 12 August. In respect of each of the three patients, he alleged that the Claimant had acted as he did for his own personal convenience and that this could constitute gross misconduct.

19. He also denied that it had been necessary for Mrs Rose to have specialist orthopaedic input. However he indicated that he would be willing to commission a 'desktop' review by an independent orthopaedic surgeon; and in due course instructed Mr Tony McEvoy to do so. By letter dated 27 January 2021 Mr McEvoy provided his 'provisional thoughts'.

20. In the meantime the Claimant has remained excluded from all clinical and non-clinical work, save for substantial periods when he has been certified as medically unfit to work and on authorised sick leave.

21. On 26 February 2021 MDS issued proceedings on behalf of the Claimant. In this trial I heard oral evidence from the Claimant; and for the Defendant from Dr Goode, Mrs Rose, Dr Stephen Wiggans (Divisional Director for Scheduled Care (SC) from 2019; Deputy Medical Director from January 2021; Consultant Anaesthetist); Dr Jim Gardner (Non-Executive Director from September 2018 to December 2019; Executive Medical Director from January 2020); and Ms Lesley-Smith Payne (Deputy Director of HR and Organisational Development from October 2018). The Claimant adduced without objection the witness statement of Mr Russell Milner (Consultant Orthopaedic Surgeon at the hospital until March 2017; the Claimant's manager between November 2011 and November 2015).

22. In the light of the withdrawal of the allegations of bias and bad faith and the plenitude of contemporaneous documentary evidence, I found the oral evidence to be of relatively limited assistance. For obvious reasons but for the avoidance of doubt, nothing in this judgment involves any finding or observation on the merits of the various allegations made against the Claimant.

23. As pursued at trial and fairly summarised in Ms Misra's closing submissions, the Claimant alleges breaches of contract in three essential respects:

(i) categorisation (conduct/gross misconduct; capability);

(ii) procedural unfairness;

(iii) exclusion.

The contract : HCP/MHPS

24. Under the heading 'Initial steps when a concern is raised' (HCP 3.2), once a concern of substance has been raised with the Chief Executive he/she must ensure that a Case Manager (CM) is appointed and identifies those who are qualified for that purpose: 3.2.3.

25. In order to decide whether or not the concern can be resolved without resort to formal procedures, the CM should consult with (amongst others) PPA, the successor to the National Clinical Assessment Service (NCAS): 3.2.4.

26. Where the CM concludes that a formal rather than informal route must be followed, a Case Investigator (CI) must be appointed. The Case Manager must determine the Terms of Reference (TOR) for the investigation: 3.2.5.

27. Once the decision to carry out a formal investigation has been taken, the Practitioner should be notified of the fact of the investigation and other matters including *'The specific allegations or concerns'* and his *'…right to meet the Case Investigator to put their views…'*: 3.2.5; likewise MHPS Part I para.13.

28. At this initial stage, the CM *'should consider whether the concern may amount to an issue of conduct. This may not be a final decision, and the* [CM] *should review this decision on receipt of the* [CI]*'s report'*: 3.4.1.

29. The CI *'is responsible for leading the investigation into any allegations or concerns, establishing the facts and reporting the findings…The* [CI] *has a wide discretion in how he/she carries out the investigation so long as he/she establishes the facts in an unbiased way and adheres to the terms of reference… If the* [CI] *is a non-clinician, a Clinical Adviser should be involved where clinical issues arise…If during the course of the investigation it transpires that the case involves more complex clinical issues than first anticipated, the* [CM] *should arrange for a Practitioner in the same speciality and same grade from another NHS body to* assist': HCP 3.2.6. Further: *'Where the alleged misconduct involves matters of a professional nature, the* [CI] *should obtain independent advice from a senior clinician in the same speciality as the Practitioner'*: 3.4.2.

30. The CI *'does not make the decision on what action should be taken nor whether the employee should be excluded from work or restrictions to practice applied…*'. The report of the investigation *'should give the* [CM] *sufficient information to make a decision whether: There is a case of misconduct that should be put to a conduct panel…There are concerns about the Practitioner's performance that should be further explored by the* [PPA]: 3.2.6.

31. Having received the completed report, the CM *'will then decide the course of action that needs to be taken'*; and having done so will write to the Practitioner, enclosing a copy of the report together with the statements and other evidence gathered in the course of the investigation; and the letter *'must set out the* [CM]*'s decision and the reasons for it'*: 3.2.8.

32. Likewise, the CM *'will* [having consulted with various identified persons/bodies] *'consider the classification concerns about the Practitioner. If the* [CM] *concludes that the concern is one of conduct the remainder of this Part* [4] *of this policy section will be followed. If the concern is one of capability, Part 5 should be followed…'*: 3.4.3.

33. Where the CM concludes that the alleged concern or issue is a conduct matter, he should invite the Practtitioner to a meeting at which he will be informed of matters including *'Clear and complete details of the allegations including (if not already received) a copy of the* [IR] *and any supporting appendices (including witness statements)…'*: 3.4.5.1.

Misconduct

34. Examples of misconduct are not provided in the HCP; but the MHPS states that *'Misconduct can cover a very wide range of behaviour and can be classified in a number of ways, but it will generally fall into one of four distinct categories: A refusal to comply with reasonable requirements of the employer; an infringement of the employer's disciplinary rules including conduct that contravenes the standard of professional behaviour required by doctors and dentists by their regulatory body; The commission of criminal offences outside the place of work, in particular circumstances, amount to misconduct; Wilful, careless, inappropriate or unethical behaviour likely to compromise standards of care or patient safety, or create serious dysfunction to the effective running of a* service': Section III, para. 4. Further: *'Examples of misconduct will vary greatly'* and the employer's Code of Conduct *'should set out details of some of the acts that will result in a serious breach of contractual terms and will constitute gross misconduct'*: para. 5.

35. The Defendant's Disciplinary Policy, which is to be read in conjunction with the HCP (p.2), provides that Gross Misconduct *'is behaviour or an offence that so undermines the trust and confidence the Trust has in an employee that he/she cannot be retained in employment in any capacity with the Trust*: 4.7.2. By Appendix 2 of that Policy, the non-exhaustive list of offences that constitute Gross Misconduct includes: *'A8 Ill-treatment of and/or sexual offences against patients…A17 Any act or omission constituting serious negligence in a member of staff's performance of his/her duties…A22 Bringing the Trust into serious disrepute…A28 Any action/omission which can reasonably be judged to have resulted in a complete lack of confidence/trust in the individual by the Trust.'*

36. The Disciplinary Policy also provides under 'Principles' that *'Employees should be informed of the allegations against them and given full opportunity to state their case before any decision is reached'* (1.2); and that where a disciplinary meeting has been arranged *'Reasonable notice (normally 7 days) will be given including who will be present at the hearing. This notice will be confirmed in writing and the management statement of case* [MSOC] *detailing the allegations, any witness statements and supporting documents will be distributed to all relevant parties…The employee will be*

given the opportunity to respond to the [MSOC] *and may provide a written or verbal submission…*': 4.5.

Capability

37. Under HCP Part 5 (Capability Procedure), there is a non-exhaustive list of matters which the Trust may regard as being concerns about capability : *'Out of date or incompetent clinical practice (unless this is contrary to clear management requests made previously in which case the issue may be one of misconduct – see Part 4)*; *Inappropriate clinical practice arising from a lack of knowledge or skills that puts patients at risk; Inability to communicate effectively; Inappropriate delegation of clinical responsibility; Inadequate supervision of delegated clinical tasks; and Ineffective clinical team working skills.'* Save for the parenthesis this reflects the non-exhaustive list in the MHPS.

38. The Part 5 procedure begins with the provision that initial consideration must be given as to whether any failure or concern in relation to a Practitioner was due to broader systems or organisational failure. If so, appropriate investigation and remedial action should be taken. Further wherever possible, issues of capability shall be resolved through ongoing assessment, retraining and support. If the concerns cannot be resolved routinely by management, the [PPA] must be contacted for support and guidance before the matter can be referred to a capability panel: Part 5 para. 3.5.1.

39. If it is decided to apply the capability process, the options available to the CM for dealing with the matter are: no action is required; retraining or counselling should be undertaken; the matter should be referred to the [PPA] for their consideration; or referral to a capability panel for a hearing: para.3.5.3.

40. The MHPS also provides that in capability cases consideration should be given to whether an 'action plan' to resolve the problem can be agreed with the practitioner; and that advice on the practicability of this approach should be sought from the [PPA]. If the nature of the problem and a workable remedy cannot be determined in this way, the CM should seek to agree with the practitioner to refer the case to the PPA which can assess the problem in more depth and give advice on any action necessary: Section II para.8.

Overlap

41. The HCP and MHPS deal with cases of overlap between conduct and capability as follows:

HCP : *'In the event of an overlap between issues of conduct…and capability, then usually both matters will normally be heard under the capability procedure. In exceptional circumstances, it may be necessary for issues to be considered under separate procedures. The decision as to which procedure shall be initiated and shall be taken by the Case Manager in consultation with the Director of Workforce and Organisational Development, and the* [PPA]*'*: 3.5.2.

MHPS : *'It is inevitable that some cases will cover conduct and capability issues. It is recognised that these cases can be complex and difficult to manage. If a case covers more than one category of problem, they should usually be combined under a capability*

hearing although there may be occasions where it is necessary to pursue a conduct issue separately. It is for the employer to decide on the most appropriate way forward having consulted with a [PPA] *adviser and their own employment law specialist*': Part IV para.8.

Grievances

42. MHPS: *'If a practitioner considers that the case has been wrongly classified as misconduct, he or she (or his/her representative) is entitled to use the employer's grievance procedure'*: Part III para.9.

43. Grievance Procedure: *'The following are excluded from this procedure and the appropriate policy should be used…Disciplinary matters…'*: para.3.1. *'Overlapping grievance and disciplinary cases: in accordance with section 3.1 of this Procedure, Grievances cannot be submitted relating to the way in which Disciplinary investigations are conducted'*: para.4.5.

Exclusion

44. HCP Part 3 : *'Under this procedure the term "excluded from work" is used to replace the word "suspended". The word "suspension" should not be used when dealing with a Practitioner as it can be confused with suspension from the register by the GMC or GDC. Exclusion is a last resort and can only be justified on the grounds set out below. Before the decision is taken to exclude any Practitioner, all other options must have been thoroughly explored, for example restricting a Practitioner's* duties': 3.3. Para. 3.3.1.1 identifies those entitled to exclude or restrict a Practitioner.

45. *'It will usually be for the* [CM] *to make the initial decision whether to exclude or restrict a Practitioner. However there may be circumstances where the* [CM] *may not have the authority to exclude in which case the officers in paragraph 3.3.1.1 will make this decision. A decision to exclude a Practitioner will only be made once it has been decided that there are significant concerns about the Practitioner's conduct or capability and the conditions set out in paragraph 3.3.2 have been satisfied'.*

46. Para. 3.3.2 sets out four types of temporary restrictions which the Case Manager must consider at the outset if a serious concern is raised about a Practitioner and if temporary restrictions on his/her practice are necessary. These include amending or restricting clinical duties; restriction to non-medical duties; and absence due to ill health.

47. By para. 3.3.3: *'Exclusion is a temporary measure reserved for specific circumstances. Alternatives to exclusion must always be considered in the first instance. The key factors in any decision to exclude are; the protection of staff or patient interests or potential impact on the investigation.'*

48. There are two types of exclusion, 'Immediate' and 'Formal'. The right to exclude immediately is in a circumstance referred to in para. 3.3.2 *'where no alternative is deemed appropriate by the officers listed at paragraph 3.3.1.1, the Practitioner may be excluded immediately to allow preliminary consideration of the concerned by the* [CM] *and* [CI]*'*: 3.3.5.1. The initial period of immediate exclusion is a maximum of 2 weeks, following which whether to exclude formally must be made in accordance with that procedure: 3.3.5.2.

49. The right to exclude formally can only take place after the CM assesses there is a case to answer as a case conference with the Director of Workforce and Organisational Development; a preliminary report has been prepared by the CI which indicates there is misconduct/capability concern or further investigation is warranted; a meeting has been held with the Practitioner in accordance with paragraph 3.3.5.3; and the PPA has been consulted: 3.3.6.1.

50. Formal exclusion *'can only be justified where there is a need to protect patient or staff interests pending the full investigation of: Allegations of misconduct; Concerns about serious dysfunction in the operation of clinical services; Concerns about lack of capability or poor performance; or Where the Practitioner's presence is likely to hinder ongoing investigations. Other options such as restrictions of practice must be considered. Exclusion is to be used only where it is strictly necessary for the reasons set out above*': 3.3.6.2.

51. The practitioner should be informed of the exclusion in a meeting with the Medical Director and/or the CM; and *'The reasons for the exclusion must be explained and the Practitioner shall have an opportunity to respond and suggest alternatives to exclusion*': 3.3.6.3.

52. The CM must conduct a second and third review of the Practitioner's formal exclusion at 4-weekly intervals; and the review report must address *'Any change of circumstances since the original decision to* exclude': 3.3.12.2. If a Practitioner has been excluded for three periods and the investigation has not been completed, the CM must submit a written report to the Chief Executive and Designated Board Member which includes the reasons for the continued exclusion, why restrictions on practice are not appropriate, the timetable for completing the investigation and reasons for delay: 3.3.12.2. Exclusions should not normally last for more than six months unless a criminal investigation is ongoing: 3.3.12.3.

Good medical practice (GMP)

53. This is published by the General Medical Council (GMC). Under the section 'Domain 3: Communication, partnership and teamwork' this includes the following provisions:

Communicate effectively

31 You must listen to patients, take account of their views, and respond honestly to their questions

Working collaboratively with colleagues

35 You must work collaboratively with colleagues, respecting their skills and contributions

36 You must treat colleagues fairly and with respect

…38 Patient safety may be affected if there is not enough medical cover.

Continuity and coordination of care

44 … You must:

a. *share all relevant information with colleagues involved in your patients' care within and outside the team, including when you hand over care as you go off duty…*

b. *check, where practical, that a named clinician or team has taken over responsibility when your role in providing a patient's care has ended…*

54. Under 'Domain 4: Maintaining trust' it includes:

Treat patients and colleagues fairly and without discrimination

56 You must give priority to patients on the basis of their clinical need if these decisions are within your power…

57 The investigations or treatment you provide or arrange must be based on the assessment you and your patient make of their needs and priorities, and on your clinical judgement about the likely effectiveness of the treatment options. You must not refuse or delay treatment because you believe that a patient's actions or lifestyle have contributed to their condition

58 *You must not deny treatment to patients because their medical condition may put you at risk*

65 *You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession*

68 *You must be honest and trustworthy in all your communication with your patients and colleagues'*

71 *'…You must make sure that any documents that you write or sign are not false or misleading.*

Law : categorisation

55. In Skidmore v. Dartford and Gravesham NHS Trust [2003] UKHL 27; [2003] ICR 721, the House of Lords considered the earlier version of the contractual NHS disciplinary procedure known as Circular HC(90)9 and the distinctive procedures which it applied as between allegations of 'professional conduct' and 'personal conduct'. These provisions included that *"It is for the authority to decide under which category a case falls"*. The House held that this was not a provision whereby the employer's decision on categorisation was final subject to bad faith or irrationality; rather it *'merely states the obvious: the trust must make the initial decision to commence the appropriate disciplinary* procedure': per Lord Steyn at p.728G. The contractual position was that: *'The trust is entitled to decide what disciplinary route should be followed. That decision must, however, comply with the terms of the contract. If a non-conforming decision is taken and acted upon, there is a breach of contract resulting in the usual remedies'* : p.728E-F. Further, *'The contract was entirely workable on the basis that the authority had to decide on categorisation but it had to do so in accordance with the contract'* : p.729D. The Court upheld the decision of the Court of Appeal that the characterisation by the Trust had been wrong and that the conduct in question fell to be characterised as professional, not personal.

56. In the MHPS case of Idu v. East Suffolk and North Essex NHS Foundation Trust [2019] EWCA Civ 1649; [2020] ICR 683 the Court of Appeal applied the principle in Skidmore, summarised as : *'…the correct characterisation of the conduct charged was a matter for the court and not for the trust…'* [17] ; see also Mattu v. University Hospitals Coventry & Warwickshire NHS Trust [2012] EWCA Civ 641; [2013] ICR 270 at [81].

57. In further guidance, Idu included *'…(5) It is also legitimate to attach weight to the fact, if it be the case, that a doctor has not in the disciplinary proceedings themselves challenged the trust's characterisation of the allegations in question…No doubt how much weight can be given to that fact will depend on the particular circumstances'* : per Underhill LJ at [26].

58. The Skidmore approach contrasts with contractual terms which give one party to a contract the power to exercise a discretion or form an opinion as to relevant facts; and with the consequence that the Court may only intervene on the basis of an implied term that the power should be exercised in good faith and without being arbitrary or capricious or irrational in the sense that is used when reviewing decisions of public authorities: Braganza v BP Shipping Ltd [2015] UKSC 17; [2015] ICR 449; also IBM United Kingdom Holdings Ltd v. Dalgleish [2017] EWCA Civ 1212; [2018] ICR 1681. The Defendant submits, and the Claimant disputes, that this provides the correct approach in the present case.

59. As to the categorisation of a matter as constituting 'gross misconduct', in Chhabra v. West London Mental Health Trust [2013] UKSC 80; [2014] ICR 194, the Supreme Court held that there had been a number of irregularities in the proceedings which had cumulatively rendered the convening of the conduct panel unlawful as a material breach of her contract of employment. The first example was the case manager's conclusion that there was a case to answer in respect of gross misconduct. Lord Hodge held that the case investigator's findings of fact and evidence were not *'capable when taken at their highest of supporting a charge of gross misconduct'* [35].

60. In Ardron v. Sussex Partnership NHS Foundation Trust [2018] EWHC 3157 (QB); [2019] IRLR 233, Jacobs J cited Chhabra at [35] for the proposition that *'…the question for the Court is whether the findings of fact and evidence as found by the case investigator, when taken at their highest, are capable of supporting a charge of gross misconduct*: [71]. Further: *'The question of whether the findings of fact and evidence are capable of supporting a charge of gross misconduct is an issue of law for the Court: see* Skidmore*…paras.[15]-[17]. Accordingly, the issue is not to be determined by the application of public law principles; e.g. by asking whether the case manager's decision took into account all relevant considerations, or was such that no reasonable case manager could have made. However, in an area involving technical matters which are outside the Court's ordinary expertise, the court should have proper respect for the views expressed by experts including, in the present case…'.*

61. Further *'The concept of 'gross misconduct' in the employment law context, connotes misconduct which justifies summary dismissal, and which therefore amounts to a repudiatory breach of contract. There is no fixed rule of law defining the degree of misconduct which will justify dismissal…The focus is on the damage to the relationship between the parties. Dishonesty and other deliberate actions which poison the relationship will obviously fall into the gross misconduct category, but so in an*

appropriate case can act of gross negligence…Very considerable negligence, historically summarised as 'gross negligence' is therefore required for a finding of gross misconduct' [78].

62. In Al-Obaidi v. Frimley NHS Foundation Trust [2019] EWHC 2357 (QB); [2019] IRLR 1065, Elisabeth Laing J (as she then was) observed that Braganza had not been cited in Ardron; and concluded that in Chhabra the relevant test had been assumed rather than decided. She held that the question of whether a matter should be referred to a disciplinary hearing involved a *'three-fold discretion…analogous to the employer's contractual discretion in the* Braganza *case to decide whether an entitlement to death in service benefit was excluded by the employee's suicide'* [40]. However, on the facts of the case, it made no difference whether it was a Skidmore or a Braganza case; and she would therefore *'…assume that the question I have to answer is whether the findings of facts and evidence in the investigation report were capable, taken at their highest, of supporting, prima facie, a charge of gross misconduct'* [42].

63. As to a mixed case of matters involving both conduct and capability, the relevant provisions in Chhabra were in similar terms to the present case: see at [15]. The Supreme Court held that this gave the Trust a discretion whether to combine issues of capability and conduct in a capability hearing: [41].

The law : procedural issues

64. In Chhabra the Supreme Court gave the following relevant guidance about the respective roles of the CM and CI under the MHPS.

65. The CI does not have the power to determine the facts: *'The aim of the new procedure is to have someone, who can act in an objective and impartial way, investigate the complaints identified by the case manager to discover if there is a prima facie case of a capability issue and/or misconduct. The case investigator gathers relevant information by interviewing people and reading documents. The testimony of the interviewees is not tested by the practitioner or his or her representative. In many cases the case investigator will not be able to resolve disputed issues of fact. He or she can only record the conflicting accounts of the interviewees and, where appropriate, express views on the issue. Where, as here, or where there is otherwise undisputed evidence, the case investigator can more readily make findings of fact*: [30]; see also at [17].

66. As to the CM: *'If the case investigator were to conclude that there was no prima facie case of misconduct, there would normally be no basis for the case manager to decide to convene a conduct panel. But if the report recorded evidence which made such a finding by the case investigator perverse, the case manager would not be bound by that conclusion. Where the case investigator's report makes findings of fact or records evidence capable of amounting to misconduct, the case manager may decide to convene a conduct panel. The case manager can make his or her own assessment of the evidence which the case investigator records in the report'*: [31].

67. As to the flexibility given to the CI and CM respectively: *'It would introduce an unhelpful inflexibility into the procedures if (i) the case investigator were not able to*

report evidence of misconduct which was closely related to but not precisely within the terms of reference…or (ii) the case manager were to be limited to considering only the case investigator's findings of fact when deciding on further procedure. Similarly, it would be unduly restrictive to require the case manager to formulate the complaint for consideration by a conduct panel precisely in the terms of the case investigator's report. I do not interpret MHPS or the trust's policies in D4 and D4A as being so inflexible or restrictive. The case manager has discretion in the formulation of the matters which are to go before a conduct panel, provided that they are based on the case investigator's report and the accompanying materials in appendices of the report…But the procedure does not envisage that the case manager can send to a conduct panel complaints which have not been considered by the case investigator or for which the case investigator has gathered no evidence': [32].

68. As to irregularities in the proceedings: *'As a general rule it is not appropriate for the courts to intervene to remedy minor irregularities in the course of disciplinary proceedings between employer and employee – its role is not the "micro-management" of such proceedings…Such intervention would produce unnecessary delay and expense'*: [39]. In the subject case, the Supreme Court concluded that there had been *'…a number of irregularities in the proceedings…which cumulatively render the convening of the conduct panel unlawful as a material breach of her contract of employment'*: [34].

69. In Ardron Jacobs J summarised the relevant legal principles in terms which included : *'(1) The role of the case investigator…is to investigate in order to discover if there is a prima facie case of misconduct. He cannot, however, resolve disputed issues of fact. The role of case manager…is to assess the evidence and decide whether there is a case which it is appropriate to send to a disciplinary panel. That includes deciding whether the matters are sufficiently serious so as to amount to a case, if proven, of gross misconduct'* [70]; *'(7) The Court is discouraged from micro-managing the disciplinary process* [and] *is not required to intervene to remedy minor irregularities in the course of disciplinary proceedings'* [76]; *'(8) The case manager cannot send to a conduct panel complaints which have not been considered by the case investigator or for which the case investigator has gathered no evidence'* [77].

70. In Burn v. Alder Hey Children's NHS Foundation Trust [2021] EWHC 1674 (QB), Thornton J's list of relevant principles added that (i) *'…it is wrong to regard the internal disciplinary process of the Trust as if it is an adjudicative process concerned with the determination of legal rights, such as occurs in a court or tribunal. In the employment context the disciplinary power is conferred on the employer by reason of the hierarchical nature of the relationship. The purpose of the procedures is not to allow a body independent of the parties to determine a dispute between them. Typically, it is to enable the employer to inform himself whether the employee has acted in breach of contract or in some other inappropriate way and if so, to determine how that should affect relations between them'* [90], citing Gregg v. North West Anglia NHS Foundation Trust [2019] EWCA Civ 387; [2019] ICR 1279; and (ii) *'Where detailed procedures are silent on the matter then the fallback is that it is a managerial discretion for the employer to decide upon in relation to that gap'* [96], citing MacMillan v Airedale NHS Foundation Trust [2014] EWCA Civ 1031.

The law : suspension/exclusion

71. The lawfulness of the suspension or exclusion of an employee is in principle determined by the implied term of trust and confidence which is implied into every contract of employment; namely that neither party shall without reasonable and proper cause conduct itself in a manner likely to destroy or seriously damage the relationship of trust and confidence between the parties.

72. An act of suspension by an employer can constitute a breach of the implied term where, by itself or in combination with other acts or omissions it (i) destroys or seriously damages the relationship of trust and confidence and (ii) is without reasonable and proper cause : Agoreyo v Lambeth LBC [2019] EWCA Civ 322; [2019] ICR 1572 at [96]-[97] following Mahmud v BCCI [1997] AC 20. For the purpose of this case the essential focus is on the second ingredient, namely whether the Trust had reasonable and proper cause for its initial and continued suspension of the Claimant from all clinical and non-clinical duties.

73. In addition the Claimant contends that the Defendant has acted in breach of express terms of the HCP/MHPS as incorporated into the contract.

Narrative/findings

74. In February 2019 the Claimant obtained approval from the Head of Department Mr Arshad Javed (Consultant Orthopaedic Surgeon) for annual leave to go to India for 2 weeks commencing Monday 28 October 2019; later revised at the Claimant's request to commence 29 October.

75. At the request of his colleague Mr Amit Shah (Consultant Orthopaedic Surgeon) the Claimant had agreed to provide cover for him as the Consultant on-call for the October weekend. In mid-October the Claimant had concerns about the possible implications for continuity of care in such an arrangement, because he and Mr Shah worked in a team, cross-covering with each other, and Mr Shah was also going to be on annual leave after the weekend. He raised these concerns in an e-mail dated 16 October 2019 to Ms Tracy Claxton (Assistant Directorate Manager, Orthopaedic Surgery) and was sufficiently reassured with her reply of 23 October as to continue with the arrangement. Whilst referring to the follow-up care which would be available while both he and Mr Shah were away, Ms Claxton's reply added that the weekend admissions would still be admitted under the Claimant's name.

76. Patient A was admitted as an emergency in the late evening of Saturday 26 October. There is no dispute that in accordance with the Claimant's instructions the Registrar on duty (Dr Saleem) booked her onto the emergency list for surgery in theatre on the following (Sunday) morning; that at the Sunday morning trauma meeting the Claimant postponed the surgery; and that this was carried out by Mr Anand on the following afternoon.

77. Patient B was admitted as an emergency at 12.35 on the Sunday. There is a dispute as to whether Dr Saleem discussed this patient with the Claimant either that day or at the trauma meeting on the Monday morning. Patient C was admitted as an emergency on the Sunday evening and was operated on by Mr Shetty on Thursday 31 October.

78. By e-mail dated 31 October Dr Wiggans advised Dr Goode and others that a consultant (Mr Anand) had raised a concern about the delay in the surgery for patient A; and that

concerns had been raised about other patients admitted under the Claimant's care over the October weekend. In consequence Dr Wiggans had asked for an immediate review of all patients admitted over the weekend; for '72 hour reviews' to be carried out as soon as possible; and for a meeting to update. He added that he could update *'regarding ongoing issues'* and stated that *'we will deal with what now appears to be a patient safety issue in addition to (accusations of) bullying*'.

79. In the course of their subsequent discussion Dr Wiggans told Dr Goode of what he had been told in a conversation with Mr Anand. This included the allegation that, in a conversation on the Monday afternoon, the Claimant had sought to blame Dr Saleem for the decision to cancel the operation on the Sunday morning.

The 72 hour reviews

80. The '72 hour rapid review for serious incidents' in respect of patient A was carried out on 31 October by Mr Anand (together with Ms Claxton and Mr Richard Matthews, Quality Manager).

81. Its brief description of the incident included that the patient had been listed on the emergency list for 27 October which was empty until midday; but that the operation had been cancelled by the Claimant and rebooked for Monday afternoon (28 October) *'as he deemed that the surgery was too complex and the ankle to*[o] *swollen for the weekend team'.* It continued that clinically it was obvious that the swelling would not improve without surgery; and that a second opinion had been taken from Mr Sreekumar (Consultant Orthopaedic Surgeon) which confirmed that the delay was critical. Mr Anand had carried out the surgery on the Monday afternoon. *'It was agreed this patient should have been operated on first thing on the 27th October and the delay will significantly impact on the patient outcome and made the surgery more complex leading to long-term disability'.* The review concluded with the answers 'yes' to the questions whether there were any immediately obvious serious breaches in safe practice procedure (*'Patient not operated on sooner – there was plenty of availability in theatre to ensure this'*), serious clinical errors and serious acts of omission.

82. The 72 hour review in respect of patient B was also carried out by Mr Anand on 1 November. The brief description recorded the admission of an elderly frail patient to A & E on 27 October at 12:35 p.m. with a suspected chest infection and a swollen painful knee. The patient had multiple medical problems and was on warfarin. He was referred to the orthopaedic on-call doctor Dr Iqbal (FY2). The patient was discussed by telephone between Dr Iqbal and Dr Saleem and the advice was not to aspirate the knee as the INR (a measure of the anticoagulant effect of warfarin) was raised. Patient details were entered on the handover sheet. Dr Saleem confirmed that he discussed the case with the Claimant as consultant on call but that *'unfortunately no Senior Orthopaedic review was carried out that day'* (28 October). The patient was subsequently re-referred and seen by the orthopaedic practitioner on-call on 29 October when it was identified that the knee was septic. By this time he had deteriorated and it was concluded that he was too unwell to undergo an anaesthetic. He later died. The conclusion was that the patient was admitted with a septic knee which was not recognised and that there was no orthopaedic consultant input provided on the Monday morning despite the patient details being entered on the handover sheet and the patient was discussed during the trauma meeting by Dr Iqbal. The three questions were each answered yes (*'Treatment delayed'*).

83. In cross-examination Dr Goode agreed that the failure to recognise the septic knee was not a matter which related to the Claimant; and at best there was a provisional conclusion in respect of handover on the Monday.

84. The 72 hour review for patient C was carried out by Mr Shetty (assisted by Ms Claxton/Mr Matthew) on 1 November. The brief description was that the patient had been admitted to A&E on 27 October following a fall causing a complex open humeral fracture. The patient was treated with a back slab. He was discussed on Monday 28 October during the trauma meeting and was agreed for surgery the same day due to the nature of the fracture. The Claimant's instruction was that following a CT scan the patient should be referred to Mr Shetty for surgery on his trauma list. He was finally operated on 31 October by Mr Shetty on his next available trauma slot. Thus there was a four-day delay in surgery. Clinical guidelines state that an open fracture should be operated on within 24 hours. The three questions were answered yes *'Surgery delayed – it should have been completed within 24 hours'*.

85. In cross-examination Dr Goode agreed that the issue concerning the Claimant was as to why there had been no surgery on the Monday. At best, the issue would be about finding someone else to do it or doing it as soon as possible.

86. On 4 November the Claimant, while in India, received an e-mail from the Defendant with 'Details of Incident' concerning Patient C and asking *'Please can you answer and close this incident'*. He replied the following day with his account, which included that he had picked up the patient's radial nerve palsy on his Monday morning ward round and the steps he had taken to contact Mr Shetty that day.

<u>Discussion with PPA 13 November/PPA letter 18 November</u>

87. In consequence of this information, Dr Goode and Dr Wiggans had a telephone conversation with the PPA (Dr Steve Evans) on 13 November. Dr Evans' letter of 18 November set out its main points.

88. The letter recorded that they had called to discuss concerns about the Claimant (identified as 'Mr 18919'); that he had been brought to the attention of the PPA previously in relation to allegations of bullying and harassment of colleagues; and that a colleague had also referred him to the GMC alleging deficiencies in his clinical management of four cases. A local investigation into his conduct had found the allegations of bullying and harassment to be substantiated and he had accepted a written warning for this. An external review of the four cases was critical of his management of only one of the four.

89. The letter continued that new concerns had come to light in relation to his management of three emergency patients whilst on call over the weekend of 25 to 28 October after which he had immediately departed for a visit to India.

90. As to patient A, Dr Goode had said that on the face of it this was a serious injury that would have warranted immediate surgical intervention that night; that the Claimant had listed the case for the next morning when the emergency theatre was available until about noon; but that he had then cancelled the case and rebooked it for the next day. There appeared to be no obvious reason for this cancellation. The patient was not taken to theatre until the afternoon of 28 October, when the injury was repaired by one of his

consultant colleagues. By this time her ankle was severely swollen, blistered and with patches of necrotic skin. She had now recovered and returned home but in the view of some colleagues the final functional outcome may have been compromised. The letter then stated *'You said that Mr 18919 was unable to give an explanation as to why he had not managed this patient himself in a more timely manner and blamed his registrar for the clinical decision-making – you believe this to be untruthful and consider that it brings Mr 18919's probity into question.'*

91. Cross-examined as to the statement that the Claimant *'was unable to give an explanation'* Dr Goode said that this would have been better expressed as 'unable to give a coherent explanation'. He was giving a second hand account of what he had been told by Mr Anand of his conversation with the Claimant after he (Mr Anand) had seen the X-rays on the Monday afternoon. Mr Anand reported that the Claimant had given successive different explanations when asked why he had not operated first thing on the Sunday. First, that the theatre (10) had been busy; then because the leg was swollen; then at a later stage that the Claimant had called him and said that the decision to cancel the case was given by the Registrar Dr Saleem. Dr Goode had not suggested to Dr Evans that he had himself spoken to the Claimant; and believed he had referred to two of the explanations given (no theatre space; swelling).

92. Patient B was a frail elderly patient admitted by the medical team with pneumonia, collapse and a hot swollen knee with a presumptive diagnosis of septic arthritis. A junior doctor elected not to aspirate the knee because of the elevated INR. The Claimant had not taken responsibility for the patient and the medical team had been obliged to re-refer him to the trauma and orthopaedics team, after which one of the Claimant's colleagues aspirated frank pus from the knee joint. The patient had subsequently died from systemic sepsis.

93. Patient C had been admitted with a complex open supracondylar fracture of the humerus. Surgical repair was delayed for several days until performed by one of the Claimant's colleagues. He had *'apparently emailed the Trust from India with what you said appeared to be a rather defensive explanation for the delay in treatment'.* Asked why the Claimant's e-mail of 5 November was 'defensive', he said that it was quite unusual to e-mail when on leave. At the time, he had not been aware that the the Claimant had been asked for an explanation.

94. The letter continued that there had been no concerns about the Claimant's clinical practice in the NHS since the NCAS case was closed in 2017 *'but you are aware of some concerns about aspects of his practice in the private sector'*. There had been ongoing concerns about professional relationships within the trauma and orthopaedics team, in respect of which PPA had carried out a team review in May 2019 (case no. 23148). That review (9 July 2019) confirmed the presence of continuing disharmony within the team and identified two individuals, of whom one was the Claimant, whose behaviour towards colleagues and particularly trainees was considered to be inappropriate. Dr Goode had said that, given the seriousness of the present clinical concerns, he would not feel able to guarantee patient safety if the Claimant were to be allowed to return to unrestricted practice on his return from India. He would act as CM and appoint a suitably trained CI from outside the trauma and orthopaedics team. They had discussed appointment of an external case investigator in view of the history of his *'somewhat difficult'* relationship with colleagues.

95. Dr Goode intended to protect the situation by formally excluding the Claimant from work on his return for a period of up to 4 weeks. They had discussed possible alternatives to exclusion, such as restriction to non-clinical practice *'but you consider that the history of bullying and harassment within the Department and Mr 18919's transference of blame to his registrar suggests that his continuing presence in the Trust would risk his impeding the course of the investigation'.* The three cases would be subject to local SIRI (Serious Incident Requiring Investigation).

Meeting 20 November

96. On 20 November 2019, following his return from India, Dr Goode saw the Claimant and advised him of the investigation and his decision to suspend him for a period of 4 weeks pending the investigation. The Claimant made no objection to this course; in his evidence he said that he was in a state of shock. By confirmatory letter of the same date Dr Goode stated that the reason for the exclusion was in relation to his management of the three emergency patients whilst he was on call over the weekend *'where there was a delay in them receiving treatment'*. The letter also stated that the SUI procedure had been instigated; and that he had considered in each case the 72 hour review which had been carried out.

SII investigation

97. In the light of the 72 hour review a Serious Incident Investigation (SII) in respect of patient A was established in November 2019; with Dr Wiggans as Case Manager and Mr Matthews as Investigation Officer. The Claimant provided a statement dated 10 January, but was not interviewed. This was carried out quite separately from Mrs Rose's investigation; and indeed her Investigation Report stated that she was not aware of any concurrent investigations relating to the Claimant.

98. Information obtained in this investigation included Mr Anand's written account (10 December; including an extract from his personal diary) that the Claimant had given successive different explanations for the cancellation of the Sunday surgery (that the theatre was busy; the leg was swollen; and that the suggestion to cancel had come from the Registrar Dr Saleem); and Dr Saleem (11 December) that the reason given for cancellation was that the ankle was swollen and needed to be elevated overnight.

Appointment of Case Investigator

99. As a preliminary to the employment of a CI, Ms Lesley Smith-Payne (Deputy Director HR) advised her colleague Emma Davies by email dated 4 December 2019 that *'The MHPS Case Investigation does not necessarily need to be clinical as the issue is in relation to conduct and failure to respond to clinical emergencies'*. Ms Davies the same day advised that Mrs Gillian Rose (*'one of our most experienced investigators and often does MHPS investigations for us'*) was willing to take on the task.

100. By email to Mrs Rose dated 18 December Ms Smith-Payne passed on the Claimant's request for access to the patient records and asked whether this should be provided before or after his interview by her. Mrs Rose responded that day that she had no problem with the relevant case notes being made available before the meeting :

'However it is important that he understands that I will be investigating delays in treatment rather than clinical decision-making. If he is intending to make a case that some of his decisions were clinically appropriate given the information available to him at the time (which I think perhaps he might), then the case investigator should be someone from an appropriate medical background, rather than myself. Has Mr K met with the Case Manager yet, and did their discussion cover these issues, do you know?' Ms Smith-Payne forwarded the email to Dr Goode.

101. By response later that day Dr Goode stated: '*The delay of treatment is still part of the clinical decision-making. No he hasn't requested a meeting'*. This response was not forwarded to her. Conversely, in a telephone discussion the same day Ms Smith-Payne told Mrs Rose that the investigation related to conduct and behaviour rather than clinical issues and did not require a medically qualified case investigator; but that Mr Javed would be available to her if she required. Mrs Rose was appointed CI.

102. In cross-examination Dr Goode said that 'I think we still felt it was around conduct and therefore we did not need an orthopaedic surgeon'; and that Ms Rose would have access to Mr Javed if there were any clinical issues; and as a physiotherapist she would have understanding of medical terminology.

Terms of Reference

103. Dr Goode prepared the TOR with assistance from Ms Smith-Payne. Whilst drafted by her following discussion with Dr Goode, I accept that it was his document. It was headed 'Terms of reference for investigation regarding allegations of the management of 3 emergency patients whilst on-call 25 – 28 October 2019 which resulted in delay in appropriate treatment'.

104. The TOR identified the 'allegations' to be investigated in bullet points as follows (I add the numbering which Mrs Rose inserted in her subsequent report, like her excluding the first which she understandably did not treat as an allegation):

The management of 3 emergency orthopaedic admissions to A & E whilst Mr Kamath was the Orthopaedic Consultant on call during the weekend of 25 – 28 October 2019;

(1) *To investigate why there was a delay in the appropriate management and treatment of these cases which has resulted in 3 Serious Untoward Investigations*;

(2) *To investigate why there was a delay in a 15 year old patient being taken to Theatre with a limb threatening injury. Theatre was booked for Sunday 27 October by Mr Saleem, Registrar who contacted the on call Orthopaedic Consultant*;

(3) *To investigate why the surgery did not go ahead on 27th October 2019, as the patient was listed on the emergency list for Sunday, 27 October 2019. To establish if the Theatre slot was cancelled by Mr Kamath and rebooked for Monday, 28 October 2019 in the afternoon, and if so why*;

(4) *To investigate why there was no Senior Orthopaedic review of an elderly frail patient who was admitted to A&E on Sunday 27th of October 2019*;

(5) *To investigate why the patient admitted to A&E on 27 October 2019 with an open fracture following a fall was not operated on until 31 October 2019*;

(6) *To investigate why there was a 4 day delay in surgery for this patient*;

(7) *To investigate the 3 incidents to establish if the delay in receiving treatment was negligent and caused any harm to the patients*;

(8) *To investigate if Mr Kamath's conduct has fallen short or is in breach of the GMC Good Medical Practice Guidelines; Domain 4: Maintaining Trust?'*;

(9) *To investigate if Mr Kamath's conduct has fallen short of the GMC Good Medical Practice Guidelines: Domain 3: Communication, Partnership and Teamwork?'*

105. In cross-examination Dr Goode said that the TOR were 'predominantly around delay'. As to (1), this concerned overall management, which would include clinical management. As to (2), delay can be part of clinical decision-making and can be part of conduct; but from the information they had it was looking more like conduct. He accepted that there were clinical elements to 'appropriate management' but the predominant concern was delay. As to (3), he agreed that delay can involve a clinical element. As to (8), he agreed that 'negligent' means clinical negligence 'in the main'; and said that clinical issues may become apparent in the investigation. As to (9) and (10), these were predominantly concerned with whether his conduct had fallen short. There was no express reference to probity, but that was implicitly engaged by the reference to Domain 4 which is headed 'Maintaining trust'. There was no need for that to be expressly spelled out. As to para. 56 in that Domain (beginning *'You must give priority to patients on the basis of their clinical need*'), you would need to consider whether or not there was clinical need. He agreed that the answer to that question might go to whether it was a matter of conduct or capability – 'that was the point of the investigation'. The investigation would give a steer as to whether it was conduct or capability or some mixture of the two.

106. In cross-examination Ms Rose said that her brief was to work to the TOR. If the investigation had involved analysis of detailed clinical decision-making, then it would have been for her to involve an appropriately qualified clinician. As to TOR (1), she read it as an open invitation to look at the management of three orthopaedic admissions. It did not say 'clinical management', so her understanding was that she was being asked to look at delays in the three incidents. She agreed that it would be necessary to work out what is the appropriate management. As to TOR (2), the assumption was that there had been a delay in appropriate management. As to (3), there was an assumption of fact that there had been a delay. In each case she had taken that as a starting point. She agreed that it was necessary to start with a benchmark of what should have happened; and that may be a clinical issue. As to (4), it was necessary to understand the workings of the Department on Sundays for emergencies. As to (7), her ability to deal with this depended on whether it was 'clinical' or 'ordinary' negligence. She thought she was considering the management of the patient in terms of the delays in treatment, not the treatment itself. As to (8) and (9), she interpreted this as whether in all the circumstances the Claimant had breached Domains 3 and 4. She did not feel at any point that she needed to consult an orthopaedic surgeon to further her understanding of what had gone on.

107. Mrs Rose interviewed the Claimant on 6 January 2020. On 31 December 2019 the Claimant was allowed to inspect the relevant patient notes on site (and to take his own notes having done so). Also present at the interview were his adviser from the Medical Defence Union (MDU) Dr Oliver Lord and Ms Ayres (HR officer). The Claimant began by reading from a Duty of Candour statement. This began: *'I'm really sorry that an unintended adverse outcome was reported to patients admitted under my care on the weekend of 26 to 28 October 2019. This I understand was due to a delay in them receiving treatment. It is not the outcome that any of the patients would have liked to see nor would I have wanted for the patients. All I can do is say sorry and have taken cognizance of the events leading up to these events so that we can avoid it happening again. I would have apologised to all my patients and their carers in person if this was brought to light to me earlier and am remorseful that this was brought to my attention through the MHPS process my initial concern of the lack of continuity of patients admitted under my care following my being away for three weeks post on-call contributed significantly and was a mitigating factor in two of the three cases. As part of my reflection and remediation which I have highlighted with the individual cases I have strived to follow all domains of good medical practice set up by the General Medical Council.'*

108. Questioned as to patient A, he referred to the complexity of the case (a Bosworth fracture); his concern about the swelling and that a delay may be necessary to allow the soft tissue to improve; his conclusion that it would be best to wait for the swelling to settle down prior to surgery; and the advantages of this being carried out by Mr Anand who had a specialist interest in lower limb injuries. The interview notes record Mrs Rose stating *'I am happy with your explanation and you will be sharing the paperwork with us?'* and *'I have no questions on that case…'* In cross-examination she stated that it would be unusual to accuse someone of lying in the interview; but that she would have questioned him on that if she had thought that he was not been honest, truthful or plausible.

109. As to the events of Monday 28 October, the Claimant's account included reference to his usual Monday trauma meeting at 8 a.m.; clinic later that day at the Spire private hospital; the breakdown of his car; a visit to his son in hospital in Leeds; and attempts to make contact with Mr Shetty. In addition, Ms Rose interviewed Dr Saleem and Mr Shetty.

Investigation Report

110. Mrs Rose duly produced her Investigation Report (IR) dated 13.2.20. This set out her findings of fact and then her conclusions in respect of each of the 9 itemised TOR.

111. As to TOR (1), the findings included reference to the cover arrangements for the October weekend and the various events of Monday 28 October. It continued: *'VK maintained that the on call and leave arrangements for this weekend and the following week were major contributing factors to the clinical incidents which took place, however the 72 hour rapid reviews, and witness statements suggest that it was VK's decision making and communication that was the main issue'*. The conclusion section stated *'There is evidence that a lack of effective communication by VK contributed significantly to these delays.'*

112. As to TOR (2) and (3) – patient A - , the findings recorded 'clear evidence' that patient A had been booked by Mr Saleem for theatre on the Sunday morning; and that it had been the Claimant's positive decision to cancel that slot on Sunday and rebook for Monday afternoon. It then recorded the three reasons given by him for the cancellation: no theatre space; swelling and benefit of delay; advantage of surgery by a consultant with paediatric foot and ankle expertise.

113. The IR continued that this was at odds with the evidence provided by Dr Saleem who had explained that the case was high-risk emergency and that some surgeons would not even have waited until Sunday morning; that there was space in theatre and the case had already been listed; and that clinical opinion differed about the risk of surgery on an oedematous ankle in this situation *'but other colleagues that* [he] *had worked with would, in his view, have chosen to operate as soon as possible'*; that he did not consider it justifiable to defer for the purpose of surgery by a consultant with lower limb paediatric experience; that he did not feel that the reasons for the cancellation had been adequately explained to him at the time; nor that there was the opportunity for a full debate, as it was not possible to argue constructively with the Claimant compared to other consultants.

114. The conclusion section stated that : *'It is clear that the Sunday theatre slot was cancelled by VK, and rebooked for Monday afternoon. The case was undoubtedly complex and VK maintains that there were valid clinical and operational reasons for postponing surgery, but this view is not supported by his clinical colleagues. There is evidence that VK did not openly discuss his decision with anyone for postponing surgery. VK stated* "on hindsight as soon as I had made the decision to cancel the patient from the list…I could have explored this possibility of referral to another centre". *Had he done this it would have been an opportunity to discuss his decision with another specialist, and jointly agree the best course of action.'*

115. As to TOR (4) – patient B - the findings recorded the patient's age and frailty; examination by Dr Saleem who decided not to intervene further at the time in view of his condition; that Dr Saleem was comfortable with the decision he had made and had informed the Claimant, who could have visited the patient if he had any concerns. As an experienced registrar he did not feel that a senior review was essential at the weekend. However there was no senior review on the Monday *'and FS had concerns that there was a lack of onward communication from VK about this patient to the colleagues who would be covering his leave'*. The findings recorded Dr Saleem's statement that he had discussed the case with the Claimant in a routine telephone call at the weekend when other patients were also discussed; and the Claimant's statement that he had no recollection of the case and did not believe he was contacted about it. He believed that there was a 'systems failure' in the management of the patient due to the consultants' on-call and annual leave arrangements. This section concluded : *'However the Monday was a working day for VK (notwithstanding his car breakdown and his unplanned visit to Leeds), and it is reasonable to expect that he would have ensured appropriate transfer of care for all his patients before going on leave the next day'.*

116. The conclusion section stated: *'VK recognised this should not have happened and describe it as a 'systems failure'. There is evidence that the situation would not have arisen had his communication with colleagues been more effective.'*

117. As to TOR (5) and (6) – patient C - the findings recorded the patient's admission with a complex open humeral fracture; that the Claimant was aware that clinical guidelines recommended operating on such cases within 24 hours but that *'he felt that as the patient had consumed alcohol he would not be ready for surgery until Monday p.m.'*; he also felt that due to the cases already listed it would not be possible to add this patient to the Monday p.m. trauma list; as the Claimant would then be away the plan was to refer him to Mr Shetty. This was agreed at the Monday trauma meeting but the Claimant later visited the patient and realised there was nerve involvement which increased the urgency of the case. He attempted to contact Mr Shetty when both of them were at the Spire private hospital on the Monday but failed to do so because Mr Shetty was in theatre. He then dictated an urgent letter of referral to him and followed this with an email referral on the Monday evening. Mr Shetty stated that it would have been possible to contact him by phone, but this did not happen. He was not in the hospital until Wednesday when he read the email, visited the patient and arranged for surgery the next day. The Claimant had stated that on reflection he should have had a more detailed handover with Mr Sreekumar regarding the case; and also thought that another option would be to discuss the case with the trauma coordinator, and felt this was a missed opportunity.

118. The conclusion was that *'There is evidence that inadequate communication resulted in a delay to this patient's care'*.

119. As to TOR (7) and patient A, the findings recorded that the 72 hour review had identified a likelihood of long-term complications exacerbated by the delay in surgery; and that the Claimant had expressed a different clinical view, i.e. that due to the level of swelling earlier operating would have risked long-term complications. It stated: *'This was clearly a difficult case that there is no evidence that VK made any attempt to discuss this openly with FS or anyone else before deciding to postpone surgery'*.

120. As to TOR (7) and patient B, the findings stated that due to the serious and complex nature of his overall condition it was not possible to be certain of the impact of delay in orthopaedic review. However, although earlier intervention may not have changed the outcome, *'this was not known at the time, and an earlier senior review would have been appropriate'*.

121. As to TOR (7) and patient C, Dr Saleem had confirmed that the patient had made a full recovery with no long-term or permanent damage. However the nerve involvement may have progressed *'…and the fact that there was a gap in the patient's continuity of care between Monday morning and Wednesday afternoon could have contributed to a worse outcome.'*

122. In each case the conclusions on the issue of negligence were that *'There is no evidence that VK was intentionally negligent towards these three patients. However there is evidence that the way in which VK communicated with his colleagues contributed significantly to the fact that : Patient A experienced actual harm, and there is a view (albeit not shared by VK) that earlier surgical intervention would have resulted in a better outcome; Patient B experienced a delay in senior review which may have resulted in harm (although complex co-morbidities make it impossible to fully establish the impact); Patient C experienced a delay in surgery which was not in line with clinical guidelines and could have resulted in harm.*

123. As to TOR (8) - breach of Domain 4 'maintaining trust' - the findings first referred to GMP paras. 56 and 57 (but not that part of 57 which referred to clinical judgment). The three patients *'experienced all delays in care, as established in the 72 hour rapid reviews of their cases, and supported by the interview evidence from witnesses. This suggests that they were not appropriately prioritised and that their treatment did not fully meet their needs.'*

124. The conclusion was that: *'There is evidence that VK did not appropriately prioritise patients A B and C, and that as a result the treatment did not fully meet their actual or potential clinical needs. This suggests that* [his] *conduct has fallen short of… Domain 4: Maintaining Trust'.*

125. As to TOR (9) - breach of Domain 3: Communication, Partnership and Teamwork - this first cited from GMP paras. 44(a) and (b). The findings included that patient A was a complex and unusual case, *'but VK did not have an open discussion about treatment options, making a unilateral decision to cancel surgery on the Sunday'.* As to patient B, the Claimant's team were unaware that he had not had a senior review. As to patient C, Mr Shetty was not aware that he had been referred; and Mr Sreekumar was unaware that Mr Shetty had not received the referral, nor that there was nerve involvement. However it continued that the Claimant had cooperated fully with the investigation and had provided all the information requested and also comprehensive documentary evidence. Since these incidents he had reflected, identified lessons learned and undertaken remediation including training updates - citing also from the apology recorded at the outset of his statement. Further his personal circumstances on 28 October should also be considered; completing his final day at work for a long holiday and after a busy weekend; his cross-cover consultant on leave; working the weekend with a registrar from a different team; the car breakdown on Monday which made him late for the Spire clinic; and the trip to his son in hospital: *'These factors may have made his handover less effective than it would otherwise have been'.*

126. The conclusion section focused on communication difficulties: *'There is evidence that there are relationship difficulties within the wider orthopaedic team.* [Dr Saleem] *noted that he and colleagues find VK difficult to communicate with, and VK and* [Mr Shetty] *have had previous disagreements. VK was concerned from the outset that there would be problems with this on-call weekend, and rather than responding with extra vigilance, he appears to allow this to become a self-fulfilling prophecy. This lack of a fully cooperative team approach may have contributed to the failures in communication evident during these incidents. There is evidence that VK failed to ensure that all relevant information was adequately shared with colleagues when he went off duty to go on leave. There is also evidence that VK did not check that a named clinician had taken over responsibility for his patients. This suggests that* [his] *conduct has fallen short of…Domain 3…'*

<u>Dr Goode's letter 24 February 2020</u>

127. The report was duly considered by Dr Goode. As set out in his letter to the Claimant dated 24 February he concluded that it was necessary for the allegations to be considered at a Disciplinary Hearing convened under Part 4 HCP and the Disciplinary Policy.

128. The letter described these allegations as *'in relation to your conduct'.* These *'allegation/concerns'* were summarised in terms of 8 issues which, with one exception, reflected the 10 issues in the Terms of Reference. The only significant difference was that the issue in TOR(7) was revised so as to exclude the reference to negligence and confine it to the effect of delay.

129. Having set out these issues, the letter continued that, if proven, this would constitute a breach of the Defendant's Disciplinary Policy in respect of Gross Misconduct; citing paragraphs A8, A17, A22 and A28 of the Appendix 2 examples of gross misconduct. Accordingly one possible outcome of the hearing was a summary dismissal.

130. It stated that as the allegations included issues of professional misconduct, the hearing panel would consist of two directors of the Defendant and a panel member who was medically qualified at consultant level and not currently employed by the Defendant. The supporting evidence would consist of the IR and its 19 supporting appendices. The witnesses to be called were Mr Shetty and Dr Saleem. The disciplinary hearing was subsequently fixed for 23 April.

Settlement proposals

131. By without prejudice letter to Dr Goode dated 26 March (privilege for which has been waived in these proceedings) Dr Oliver Lord, Medico-Legal Advisor of the MDU wrote on behalf of the Claimant in terms which proposed that the matter proceed to an agreed warning and an action plan in lieu of a disciplinary hearing. It began by stating that, whilst the Claimant did not agree with all the comments made by other witnesses, *'he does accept his management of the patients could have been better'.* It stated that he would reflect on the cases and proposed to audit his practice for timing of treatment of trauma patients; would have a lower threshold for seeking colleagues opinions *'in the moment rather than waiting'*; and set out various steps by way of remediation that he intended to apply. Having referred to the difficulties for both practice and the conducting of hearings in the current Covid crisis and the Claimant's wish to be of service to patients, the letter continued:

'It is the MDU's view that the hearing should be vacated in any event. It appears likely to us that misconduct would be found proven on the evidence, but as the concerns are remediable this suggests it is unlikely the panel would determine that this destroyed all confidence in Mr Kamath. Mr Kamath has learnt from the incidents, reflected, shown insight and remediated. It appears this process is likely to result in a written warning and I would like to suggest that we proceed to an agreed warning now and an action plan in lieu of a hearing… We are also aware that your primary concern will be the safety of patients and any agreement would need to have appropriate provision for management to receive assurances about the quality of care provided over the coming months.'

132. On behalf of the Defendant it is submitted that this letter provides a significant support for its contention that the allegations against the Claimant were properly categorised by Dr Goode as concerning conduct (and indeed potentially gross misconduct) rather than capability.

133. On 3 April a without prejudice conference call took place between Dr Lord, Dr Goode, Dr Wiggans and Ms Smith-Payne. The Defendant's representatives did not agree to the

proposal of a fast-track process and an agreed written warning, on the grounds that this was suitable only for minor misconduct issues, not gross misconduct: Disciplinary Policy para. 4.5.2.

134. On 6 April the Claimant had a telephone conference with Dr Lord and his representative from the BMA Mr Tom Carver. In a subsequent (21 May) letter from Mrs Kamath to the Defendant (Mr James Wilkie), she stated that in this telephone discussion *'... A perception from the MDU Representative was that there was a 95% chance of dismissal if you went to a Disciplinary hearing. He was given no choice but to consider a resignation and leave with a reference.'* Mr Kamath's evidence was to the effect that Dr Lord was reporting the Defendant's statement that there was a 95% chance of dismissal. I am quite satisfied that the Claimant is wrong about that; and that it was Dr Lord who was expressing that opinion.

135. By a related approach on behalf of the Claimant by without prejudice email to Dr Goode dated 7 April, Mr Carver put forward a settlement offer. Having referred to the recent meeting with Dr Lord, he stated that *'In return for the conclusion of the MHPS process, and thereby avoiding the need for a Hearing, Mr Kamath would agree to exit the Trust in return for an agreed reference'*.

136. In cross-examination the Claimant gave evidence to the effect that these approaches by the MDU and BMA did not have his consent. I do not accept that evidence. Whilst taking full account of his poor mental health at the time and consequent time off work, I am satisfied that neither of these experienced professional representatives would have made their approach in the identified terms without being sure of his consent.

137. The Defendant was in principle willing to look at an exit strategy on the basis of an agreed termination date as soon as possible and an agreed factual reference: see Ms Smith-Payne's e-mail to Dr Goode dated 9 April. However the Claimant went off sick at this time and matters went no further. In consequence the disciplinary hearing fixed for 23 April was vacated and subsequently re-fixed for 23 May. Pending all these matters, the Trust made successive decisions to continue the Claimant's exclusion. These included (20 February): *'You asked specifically about whether or not* [his] *exclusion should be maintained now that your investigation has been concluded. The exclusion was introduced under the provisions of Paragraph 6 of Part II of MHPS in order to protect patient safety given the nature of the concerns about* [his] *involvement in the management of the index cases…and it would therefore be reasonable for it to be maintained until these matters have been fully considered at the panel hearing. Notwithstanding this, it will clearly not be in the interests of the Trust or of* [him] *for the exclusion to be maintained any longer than is absolutely necessary and you should therefore try to expedite the hearing as far as possible'*.

138. By Occupational Health report dated 19 May following a consultation that day Dr Sue Richardson (Consultant Occupational physician) gave her opinion that in the light of his mental state the Claimant was not well enough to engage with the disciplinary process. In consequence the hearing date of 23 May was vacated and the disciplinary procedure paused.

139. By her letter to the Defendant (James Wilkie) dated 21 May, Mrs Kamath referred to her husband's mental ill health and amongst other things expressed concern that the Defendant was pursuing attempts to hold a disciplinary hearing when he was off sick.

140. By reply dated 9 June Mr Wilkie rejected the suggestion and said that the Defendant would continue to take advice from Occupational Health as to when the hearing could be rescheduled. The letter included the statement that the Defendant had a responsibility and a duty of care *'to look into any concerns in relation to clinical practice or behaviours under the MHPS process'*.

Instruction of MDS

141. In or about July 2020 the Claimant disinstructed the MDU and BMA and engaged his present solicitors (MDS) who were able to deal with both the disciplinary and employment law issues on his behalf.

MDS letter 31 July 2020

142. By their letter to the Defendant (Dr Jim Gardner, Medical Director) dated 31 July MDS made complaint in respect of various aspects of the ongoing disciplinary proceedings. These were set out under three heads, "categorisation of concerns", "exclusion" and "effect of undue procedure".

143. As to categorisation of concerns, the Defendant had miscategorised the clinical concerns as professional conduct concerns rather than potential capability issues. Despite the concerns being clearly clinical in nature, Mrs Rose, a non-clinician, had been appointed as CI. Contrary to HCP paras. 3.2.6 and 3.4.2 no appropriate professional advice had been obtained in the course of the investigation. The examples of capability issues in the HCP included inability to communicate effectively and ineffective clinical team working skills. Further, by HCP para. 3.5.2, in the event of an overlap between issues of conduct and capability, both matters should be heard under the capability procedure. They invited the Defendant's comments as to why this matter was deemed a conduct issue.

144. As to exclusion, the Claimant had been continuously excluded from work since November 2019; and during this time the Defendant in breach of the MHPS had failed to undertake a fair and proper process. It had continuously failed to notify the Claimant at the end of the 4-weekly periods as to whether his exclusion was to be extended and he or his representatives had had to chase the trust to ensure clarity. The prolonged exclusion had had a severe impact on him as a surgeon and would result in de-skilling. Insufficient consideration had been given to alternatives to exclusion.

145. As to the effect of undue procedure, these actions had caused him to suffer personal grief that had greatly affected his health and made him suffer irreparable reputational damage. The discussions which had taken place between his representatives and the Defendant had resulted in him being signed off from work from 8 April 2020. A substantive response was requested before any further action was taken in the disciplinary proceedings.

Mr Gardner's reply 12 August

146. By reply dated 12 August, Mr Gardner rejected these concerns. It had not miscategorised clinical concerns as professional conduct concerns nor should they have been considered as capability: *'We are clear that these are disciplinary allegations as they relate to Mr Kamath's conduct and probity. There is no overlap with capability*

processes and 3.5.2 is thus not applicable.' The Claimant had raised no such or any procedural concerns following receipt of the letter of 24 February but on the contrary had requested a 'fast track process' through Dr Lord on 26 March.

147. As to exclusion, for practical purposes his sickness absence had superseded his exclusion and it was his state of health which was currently preventing the hearing taking place. He had not been excluded inappropriately.

148. By reply dated 25 August, MDS took particular issue with Dr Gardner's reference to probity, stating *'There has been no mention of any probity concerns in the terms of reference, nor any mention of probity issues in the investigation report and this is the first time that our client has been notified of this, despite there being no evidence of any probity issues.'* As to exclusion, this had carried on from November 2019 until 23 April; and the Defendant had failed to confirm whether alternatives to exclusion had been considered. The letter concluded that the Claimant would be submitting a grievance to raise concerns formally.

Grievance

149. By letter to the Defendant of the same date (25 August) the Claimant lodged a formal grievance in respect of categorisation, exclusion and certain other matters. By reply dated 1 September the Defendant (Ms Smith-Payne) declined to accept the grievance on the basis of the provisions of its Grievance Policy para. 4.5. The letter advised that the points raised by the Claimant would be passed to the disciplinary panel for it to consider.

The SII report (patient A)

150. On 3 September the SII report in respect of patient A was completed. This had involved 'structured interviews' with 'key medical staff', but not the Claimant who had submitted his statement dated 10 January 2020. It included the finding that the Claimant's statement that there were insufficient theatre slots to accommodate the case due to other emergencies was not supported by accounts from the other doctors at the time or from theatre records of activity for that day; that the "root cause" was the cancellation of surgery by the Claimant, contrary to established guidelines and expected practice, leading to a delay in treatment; that contributory factors included that junior staff did not feel confident or able to challenge more senior colleagues or escalate concerns; and that inconsistencies identified within the report were that the Claimant stated that there were no emergency theatre slots whereas colleagues and theatre records confirmed this was not the case.

151. On 4 September MDS sent the Defendant a note that the Claimant was now fit to resume work on a phased return as from 7 September. In consequence Dr Goode reviewed the grounds for exclusion and discussed these with PPA. By letter dated 16 September he advised the Claimant and MDS that he had reinstated the exclusion from work for a further 4 weeks from 7 September *'as there is no material change in circumstances since the exclusion was put in place'.* The Defendant subsequently indicated that it wished to hold the disciplinary hearing on 12 October.

152. On 17 September the Claimant was provided with copies of the correspondence between Dr Goode and the PPA.

MDS letter 22 September 2020

153. By 'Letter before claim' dated 22 September MDS advised that the Claimant was not prepared to allow the disciplinary process to progress to a hearing otherwise than in accordance with the provisions for a capability hearing; and that in the absence of appropriate undertakings application would be made without further notice for an injunction. As to categorisation, the conclusion from the IR was that the issues were of poor communication and handover. To the extent that the Defendant considered that the Claimant's clinical judgement was an error *'it is plain that this must be an issue of capability or, at the very least, mixed capability and conduct'*. In any event it was obviously not a potential case of gross misconduct; and there had been no mention of probity concerns until Dr Gardner's letter of 12 August.

154. Further, as to patient A, Mr Anand who had carried out the operation on 28 October was never interviewed. As to patient C, the Registrar Mr Sahu, to whom the Claimant spoke to ensure that Mr Shetty was aware of the patient, was not interviewed.

Dr Goode's letter 23 November 2020

155. Dr Goode responded to this by his letter to the Claimant dated 23 November. He had reconsidered his decision but remained of the view that there was a clear disciplinary case to answer. In reaching that decision he had considered the IR and the evidence in its appendices; the subsequent correspondence from the Claimant and his representatives and had sought and obtained additional information from individuals including Mr Anand and Dr Saleem. These all provided a *'clear evidential basis'* for matters of professional misconduct to be considered at a disciplinary hearing. He continued that *'This letter provides a summary report of my analysis and sets out the allegations of misconduct that you are to face at the panel hearing'*.

156. Under the heading 'Nature of the allegations and process', the letter stated that in reviewing the IR and the Claimant's statement dated 5 January 2020 he had considered whether or not the matters therein were of a professional nature in accordance with the provisions of the MHPS. He continued *'My view that these are matters arose* (sic) *from your behaviours and your probity and should be addressed under the… Disciplinary Policy and… Concerns Procedure.'*

157. As to the suggestion that probity had not previously been raised, *'for the avoidance of any doubt, this was set out in the investigation report and my original letter of 24 February 2020.'*

158. In order to satisfy himself as CM that there was a case to answer he had sought and considered reports from other investigative processes from the same events, *'specifically the SUI reports which relies on information from Mr Anand'* and had considered this alongside Mrs Rose's investigation.

159. As to the suggestion that advice should have been obtained by Mrs Rose from a senior clinician in his speciality*, 'I do not regard your contention that the Trust has acted unlawfully in not seeking such an opinion as these matters fall within Mrs Rose's discretion and judgment and do not require specialist orthopaedic input.'* However, in order to reassure the Claimant and having reflected on it, he had arranged for an independent orthopaedic surgeon to sit on the panel.

160. He continued: *'Additionally, and exceptionally, if you still regard the Trust as being compelled to seek a prior independent professional view of the report relating to your conduct, I would be willing to commission such a view at this stage and prior to progressing to a panel hearing. I anticipate this would be a simple desktop exercise and I anticipate this can be carried out within 7 days of identifying a suitable independent professional.'*

161. As to capability issues, to the extent that the investigation had revealed additional concerns about his capability, these *'can be addressed at the conclusion of the disciplinary process.'*

162. Turning to the case of patient A, *'The content, context and nature of these disciplinary allegations are detailed below and included in the investigation report and appendices. These appear to be characterised as you having taken a decision to delay operating on Patient A so as to hand over her care to a colleague on Monday 28 October when your period of on call working was due to end;* ***in doing so you prioritised your own personal needs over those of the patient****; this left the patient in an extended period of pain and because the patient harm. To the extent that you say you took the decision because of the swelling of Patient A's ankle and/or in the knowledge that a colleague with a particular specialism in lower limb surgery would be available on Monday afternoon, your seniority and knowledge meant you were aware that notwithstanding these factors, Patient A's condition needed urgent attention and surgery…When subsequently asked to explain the reasons for your decision to not operate and cancel Patient A's surgery you failed to provide a consistent/plausible account of why you chose to delay Patient A's surgery; rather you sought to blame your registrar for having taken the decision cancel Patient A's planned surgery: as outlined in the summary of evidence below…*[from Mr Anand and Dr Saleem]. *Your decision and actions in* ***postponing a patient's surgery for your personal convenience and not for legitimate medical reason****, and then seeking to blame your junior colleague appears to me to be unprofessional in several important respects which could amount to gross misconduct as set out in Appendix 2 of the Trust's Disciplinary Policy… A8… A 17… A 22… A 28.'* (emphasis supplied).

163. As to the GMP Domain 4 ('Maintaining Trust') Dr Goode cited in particular paras.56; 57 (*'…you must not refuse or delay treatment…*); 58 (*'…you must not deny treatment…'*); 65 (*'you must make sure your conduct justifies your patient's trust in you and the public's trust in the profession'*); 68 (*'You must be honest and trustworthy in all your communications with your patients and… colleagues'*); and 71 (*'…You must make sure that any documents that you write or sign are not false or misleading…'*). As to Domain 3, he cited in particular paras.35 (*'You must work collaboratively with colleagues respecting their skills and* contribution') and 36 (*'You must treat colleagues fairly and with respect'*).

164. As to patient B, he had failed to carry out a senior review of a patient who was admitted under his care and whose name was on the handover sheet; failed to ensure appropriate transfer of his care to those colleagues taking over at the end of his on-call and during his annual leave; and in doing so had failed in his duty as senior consultant on call with overall responsibility for the patient's care and failed to communicate effectively with his colleagues. When subsequently asked why he had not carried out the senior review he had denied having been informed about patient B and categorised the events as a systems failure arising from the consultants' on-call and annual leave arrangements. In

conclusion: *'Your actions in not undertaking a senior review and ensuring a proper handover of Patient B's* ***for your personal convenience****, and seeking to explain your actions as a systems failure, appears to me to be unprofessional in several important respects which could amount to gross misconduct…'*(emphasis supplied), citing the same examples in appendix 2 of the Disciplinary Policy and the same provisions of the GMP.

165. As to patient C, the Claimant had been aware of clinical guidelines that recommended such fractures require surgery within 24 hours. He had reviewed the patient and suggested in his statement that his decision to postpone surgery until Monday afternoon was because of the patient having consumed alcohol, *'albeit it is unclear whether this was recorded in the patient's notes and the accounts you gave to your colleagues about your decision are inconsistent.'* He then recited the events of 28 October including the attempts to contact Mr Shetty. In the knowledge that he had not managed to do so before commencing his annual leave he did not discuss the nerve damage (which he had observed that day) with any of his colleagues available on site or with the trauma coordinator which may have expedited the patient's surgery; had failed to properly undertake a proper handover and communicate the actions taken to Mr Sreekumar. In consequence the patient had remained on the ward until 30 October when Mr Shetty returned to work and saw the email. In conclusion: *'Your decision and actions in delaying a patient's surgery in failing to properly progress Patient C's treatment and ensure a full and proper handover of his care* ***for your own personal convenience*** *appears to me to be unprofessional in several important respects which could amount to gross misconduct'* again citing the same examples from Appendix 2 and the same provisions of the GMP (emphasis supplied).

166. Under 'Potential findings', the letter stated that it was up to the disciplinary panel to decide whether or not to uphold the allegations 'set out above' and what if any action was necessary: *'my role is to commission the investigation and arrange for the findings to be presented to the panel'*.

167. As to the remit of the hearing, *'For clarity, there are no allegations or lack of capability or incompetence made at this hearing and no such issues will be considered by the panel. This is considered to be a matter of potential misconduct and the hearing is arranged on that basis'*.

168. The letter stated that the hearing would be on 4 December. The Management statement of case and supporting evidence would be sent to him in due course and not later than 10 days before the hearing. As witnesses the Defendant intended to call Mr Shetty, Dr Saleem and Mr Anand.

169. In his evidence in Court, Dr Goode stated that this letter constituted the charges which the Claimant faced. In his witness statement he had stated that the *'... clear and complete detail of the allegations he is to face…*[are] *set out in the Ms Rose's report by reference to the Terms of Reference. If any clarity or expansion was required, the Claimant should ask myself for it. He has not. The Claimant can seek the same from the disciplinary panel'.*

<u>MDS letter 25 November 2020</u>

170. By letter in response dated 25 November, MDS stated that the CM had inappropriately undertaken further investigations, in particular with Mr Anand who was now to be called as a witness; and introduced further new material which was not the subject of the original investigation by Mrs Rose. As to the allegation of prioritising his personal convenience above patient interests, this was a new tack and the Defendant was asked to identify where this was canvassed in the course of Mrs Rose's investigation. In the circumstances the hearing on 4 December should be postponed.

Defendant solicitors' letter 27 November 2020

171. By letter 27 November the Defendant's solicitors stated that by his review Dr Goode had considered the evidence in Mrs Rose's report including the SUI report; sought clarification from Dr Wiggans who had commissioned those investigations; met Dr Saleem to seek clarification and address the alleged inconsistencies in his evidence; asked clarification questions of Mr Anand; asked questions of Mr Sreekumar; and located and analysed further additional documents copies of which were included in his letter of 23 November.

172. The letter continued that the allegations of gross misconduct had been specifically set out in Dr Goode's letter of 24 February; that the evidence in the IR suggested that the Claimant had given inconsistent and implausible accounts for the reasons why he did not operate on patients A and C; that it was therefore entirely reasonable for him to present a case that those decisions were taken for his own personal convenience. This was not a new allegation nor an attempt to change tack; but a narrative to the existing allegations of gross misconduct set out in the letter of 24 February and provided the further clarity which the Claimant had sought.

173. By letter dated 1 December Dr Goode supplied the original disciplinary pack ('Part 1') together with additional documents including interview notes and statements ('Part 2') by way of response to concerns expressed in MDS' letter of 25 November. These included notes of a meeting with Dr Saleem (26 October) and an e-mail from Mr Anand (30 November). He confirmed his view set out in his letters of 23 November; stated that the management statement of case was as set out under the heading 'disciplinary allegations' in his letter of 23 November; and advised that the hearing was postponed until 9 December.

174. By further letter dated 4 December MDS complained that this postponement was too short. Its position remained that there was a capability matter; and it would be appropriate and proportionate to appoint an independent expert to review the patient cases. In addition the theatre lists which had been supplied were illegible.

175. In the meantime on 3 December the Claimant went off sick. On 8 December his GP signed him as unfit for work until 15 January because of a depressive disorder and was awaiting a consultant appointment. In consequence the panel hearing was cancelled.

176. On 9 December the Claimant was seen by Occupational Health (Dr Gary Ferguson). By his revised report dated 7 January, Dr Ferguson concluded that the Claimant was not fit to work at present but would be fit to participate in the disciplinary process and attend the hearing.

177. In the meantime by letter dated 15 December the Defendant's solicitors reaffirmed that there were no allegations of incapability against the Defendant; and that the allegations centred around the Claimant's motivation for delaying appropriate care for his patients and issues of misconduct and probity. There was no allegation that his clinical decisions arose from a lack of knowledge or capability. Accordingly the Defendant did not believe it to be a case of mixed capability and conduct concerns. In any event the MHPS provided that where there is an overlap both matters should usually be heard under the capability procedure, but that there may be occasions where it is necessary to pursue a conduct issue separately. The Defendant believed that this latter approach was appropriate; and that if any separate issues of incapability arose from the disciplinary process, it was within the CM's discretion to address such concerns at the conclusion of the disciplinary process.

178. The Defendant also accepted that, because there are allegations of professional misconduct, the HCP (3.4.2) required it to seek independent advice from a senior clinician in the same speciality. This it would do.

179. By his sicknote dated 12 January, his GP stated that he may be fit to work on the basis of a phased return. In consequence his exclusion was continued.

Instructions to Mr McEvoy

180. By letter dated 21 January 2021 Dr Goode sent instructions to Mr A. McEvoy, a consultant trauma and orthopaedic surgeon who had agreed to carry out the proposed desktop review. The letter stated that the allegations which he had concluded should be considered by disciplinary panel *'in the main*' related to whether the Claimant had delayed appropriate care for his patients for his own personal convenience and his probity in that regard. If proven, Dr Goode considered that all the allegations were likely to be regarded as issues of potential professional misconduct; and he specifically required Mr McEvoy's advice on that point. He continued: *'Your role is necessarily restricted to providing advice on matters of professional misconduct and not on issues of clinical competence or judgment'*. He was to consider the IR and appendices and provide his independent advice on *'whether or not, as an experienced senior clinician, you consider that Mr Kamath's alleged actions highlighted within the report and my letter of 23 November 2020, if proven, would amount to professional misconduct'*.

Mr McEvoy report

181. By his response, described as *'preliminary thoughts'*, dated 27 January, Mr McEvoy considered each of the three cases. As to patient A, he identified 'optimal management', which included that *'if slot was available on the Sunday this should have been utilised. If the surgeon did not feel they had the expertise to definitively treat then option of spanning ex fix could have been used. It sounds like fracture was in an un-reduced position for greater than 24 hours leading to skin necrosis/blistering.'* He then stated *'This sounds like sub optimal management that might be considered negligent'*.

182. As to patient B, his comments included that *'I would consider that review by a competent Registrar who discusses case with the Consultant, would constitute a senior review'*; and that '*There was a significant failure of handover to the on-call/Trauma list team on Monday. This may be partly due to VK and the Registrar but may also be*

indicative of a systems failure in the way that trauma is managed/handed over in the department'. As to patient C, his comments included similar terms to the latter sentence.

183. By letter dated 9 February Dr Goode advised that the disciplinary hearing would be rescheduled for 11 March and again that there was a clear evidential basis for allegations of professional misconduct.

184. By letter dated 12 February MDS commented on Mr McEvoy's report and stated that *'the issues briefly canvassed in this report go squarely to matters of capability alone'* and asked to know if the Defendant was minded to proceed with the disciplinary hearing.

185. Proceedings and the application for interim relief were issued on 5 March; and the interlocutory order made on 15 March.

186. By letters dated 11 March and 8 April Dr Goode successively advised the Claimant that he had reviewed the exclusion and concluded that there had been no material change of circumstances; in each case adding that *'It would not be appropriate to return you to clinical duties given that you have not undertaken a clinical role since October 2019'*; and that it would not be appropriate to allow him to carry out a non-clinical role *'…when the concerns and allegations set out in previous correspondence, pertaining in part to your probity, remain unresolved.'*

Categorisation

Claimant's submissions

187. The alleged breaches of contract are in respect of the Defendant's categorisation of the matter as (i) conduct rather than capability, alternatively mixed conduct and capability and (ii) potential gross misconduct.

Conduct or capability

188. The pleaded allegation is that the Defendant *'Miscategorised the concerns as being conduct as opposed to capability or of mixed conduct and capability and failed to convene a hearing under Part 5 of the Concerns Procedure'* : POC para.50(5).

189. Ms Misra submits that the principles identified by the House of Lords in Skidmore apply to this case. As summarised by the Court of Appeal in Idu: *'…the correct characterisation of the conduct charged was a matter for the court and not for the trust…'*. By contrast the principles identified in Braganza, IBM and like cases have no application. The correct categorisation is not a matter of discretion for the Defendant; nor therefore is the Court's role limited to consideration of whether Dr Goode exercised that discretion rationally and in good faith. Alternatively, if that is the correct approach, he failed in the former respect.

190. In Skidmore and Idu the contractual distinction was between 'professional' and 'personal' conduct; and the same principles applied where, as here, the categorisation issue was between 'conduct' and 'capability'. Under the heading 'Classification of the concern', the HCP required the CM, having received the Investigation Report, to consider the classification of the concern, as between conduct and capability (para.

3.4.3). In the event of an overlap between the two, the relevant provisions of the Concerns Procedure (para.3.5.2) or if inconsistent the MHPS (Part IV para.8) should be applied.

191. The main conclusion reached by Mrs Rose in her IR was that there were a number of communication and relationship issues that had contributed to the events: see in particular paragraphs 6.2-6.8. Under the HCP the non-exhaustive list of examples of matters of capability included communication and clinical team working skills. The Defendant ought to have concluded that it raised only issues of capability.

192. Thus the issues from the conclusion section of the IR were :

TOR (1): lack of effective communication

TOR (2) and (3) (patient A): the dispute was about (i) clinical decision-making and (ii) communication

TOR (4) (patient B) : communication or 'systems failure'

TOR (5) and (6) (patient C) : communication

TOR (7): the only reference to negligence was that there was no evidence that he was 'intentionally negligent'; otherwise it identified communications issues.

193. As to TOR (8) and (9) and GMP Domains 3 and 4, their use of the word 'conduct' confused the important distinction between conduct in its broad sense of 'action or omission' and a narrow sense of 'something other than capability' and tilted the investigation away from capability to conduct matters in that narrow sense.

194. In any event in her consideration of Domain 3, the relevant sections identified by Mrs Rose (para.5.22) were from its para. 44 which fell under the sub-head of 'Continuity and coordination of care' and the overall head of 'Communication, partnership and teamwork' which were matters of capability. Her conclusions that there was evidence that the lack of a fully cooperative team approach may have contributed to failures in communication; that he had failed to ensure that all relevant information was shared with colleagues; and had failed to check that a named clinician had taken over responsibility for all his patients, were all as to capability not conduct. They contained nothing to suggest that the Claimant acting for some ulterior or improper motive. Further the acknowledged and unresolved background of a dysfunctional Department (of which Mrs Rose was not fully aware) could have been relevant at least partially as systemic reasons for communication difficulties.

195. As to Domain 4, her conclusion that there was evidence that the Claimant *'…did not appropriately prioritise patients A B and C, and that as a result their treatment did not fully meet their actual or potential clinical needs'* was a conclusion about capability not conduct. Nothing in her report stated or suggested that the alleged failings were ill-intentioned or for some ulterior or improper motive.

196. Dr Goode was wrong to state in his evidence that partnership within medical teams was a conduct matter; or that miscommunication issues could amount to conduct if it formed

part of a pattern. Unless the poor communication was intentional it could not amount to a conduct rather than a capability matter.

197. Dr Gardner's evidence, that the communication issues were not capability matters as there was no suggestion that the Claimant was not a skilled and capable orthopaedic surgeon, placed an undue focus on clinical knowledge and technical skill. Good communication and team-working were a necessary part of the requisite skills, as the HCP identified in the list of capability examples. Likewise the GMP made clear that clinical skills incorporated good communication and team-working.

198. The views of third parties were of very limited assistance. The PPA's record that the Defendant was taking the matter forward to a conduct panel (letter 20 February 2020) did not amount to an endorsement of the decision; and in any event the information provided to it had been inaccurate. The observations of the MDU and BMA had taken place in the context of without prejudice discussions on settlement; and the Court had only seen a snapshot to the limited extent that privilege had been waived.

199. In addition the Defendant had since the categorisation challenge in the MDS letter of 31 July 2020 changed the focus of its concerns from communications issues to matters of dishonesty. Its letter of 12 August 2020 had for the first time alleged that the allegations related to the Claimant's probity; and for this purpose suggested without any obvious foundation that the Claimant had prioritised his 'personal convenience' over the needs of each of the three patients; including the allegation to the effect that he had given dishonest accounts of his reason for cancelling the Sunday surgery for patient A. As to blaming Dr Saleem, this did not appear in any of the conclusions in Mrs Rose's report. Its source was Mr Anand, who had not been interviewed by her. Dr Saleem had been interviewed but had not suggested that he had been blamed. The notes of the Claimant's interview showed that he had taken full ownership of the decision not to operate on Sunday morning. As to theatre availability, the Claimant did not at any point in the investigation say that there was no theatre availability.

200. In any event, none of these matters have been put to the Claimant as part of any investigative process; which had not been about issues of dishonesty. Once an investigation was closed, the CM could not investigate the matter further. The relevant 'charge sheet' was contained within the letter of 24 February; not the letter of 23 November which was based on the allegation of acting for his personal convenience which had formed no part of the investigation.

201. In the alternative, the case was one of mixed conduct and capability. If so, there had been no consideration of the appropriate course under the 'mixed' provisions; and the present disciplinary hearing could not proceed.

Gross misconduct

202. The allegation is that the Defendant: *'Purported to raise a case of gross misconduct for consideration by the disciplinary panel which is wholly unsupported by the investigation carried out by Mrs Rose'* : para.50(8).

203. Ms Misra submits that the correct approach for the Court is as summarised by Jacobs J in Ardron, following Chhabra and Skidmore, namely whether the findings of fact and

evidence as found by the case investigator, when taken at their highest, are capable of supporting a charge of gross misconduct. This is an issue of law for the Court.

204. She submits that the Court should not follow the contrary conclusion of Elisabeth Laing J in Al-Obaidi that the question of whether there was a case to answer involved a 'three-fold discretion' which was subject to review only on Braganza principles; a case not cited in Ardron. Her conclusion was contrary to Mattu (not cited), in particular at [81], and the subsequent decision in Idu. In any event, the issue made no difference on the facts of Al-Obaidi and the judge decided the case on the assumption that the question was as identified in Ardron.

205. For the reasons given under the issue of categorisation as between conduct and capability and *a fortiori*, there was nothing in the IR and its appendices and evidence that was capable of supporting a finding of gross misconduct. The allegation that the Claimant had lied or prioritised his personal convenience over his patients had formed no part of the TOR nor the consequent investigation. In further support she cited Ms Smith-Payne's evidence in cross-examination that she did not think there was anything in the IR to support the allegation that the Claimant had acted for his personal convenience.

206. If the matter was one of discretion and subject to Braganza principles, there was no rational basis for the conclusion which Dr Goode had reached that this was a matter of conduct not capability.

Defendant's submissions on categorisation

Conduct or capability

207. Mr Gorton submits that on a proper interpretation of the contractual provisions the CM's decision as to whether the case concerns conduct or capability (or a mixed case involving both) is a matter for the exercise of discretion; and with the consequence that the Court may only intervene on the Braganza basis.

208. Thus the approach from Skidmore has no application in the present case. Skidmore and the other decisions relied on by the Claimant concerned the previous distinction between 'professional' and 'personal' conduct, whose purpose was to ensure that there was appropriate professional involvement in the investigation and determination of allegations of professional (rather than purely personal) misconduct. A 'procedural remnant' of this remained in the MHPS which provided that *'Where the alleged misconduct relates to matters of a professional nature, or where an investigation identifies issues of professional conduct, the case investigator must obtain appropriate independent professional advice'*: Part III para.2. There was no such concern where the decision was between conduct and capability; because the relevant procedures provided for specialist professional input: see HCP para. 3.4.2.

209. The language of the relevant procedural provisions further demonstrated that it was a matter for the discretion of the CM. Thus the MHPS *'It is for the employer to decide upon the most appropriate way forward, having consulted the* [PPA] *and their own employment law specialist'*: Part III para.9; Part IV para.8 (Conduct and capability); and the HCP 3.4.3 (*'If the Case Manager concludes that the concern is one of conduct'*)

and 3.5.2 (*'The decision as to which procedure shall be initiated and shall be taken by the Case Manager in consultation with…'*).

210. If it were other than a matter of discretion, reviewable only on Braganza principles, the Court would be drawn into the very 'micro-management' which was abjured by authority at the highest level and for which the Court was unsuited.

211. Further the Supreme Court in Chhabra made clear that the decision on the appropriate procedural route in a 'mixed case' involved the exercise of a discretion: *'…the trust had a discretion…whether to combine issues of capability and conduct in a capability hearing'*: [41]. For the purposes of this case he accepted that the 'mixed case' provisions were incorporated into the Claimant's contract.

212. In consequence it was not for the Court to decide on categorisation of conduct or/and capability, as if sitting in the chair of Dr Goode.

213. As to gross misconduct, the correct approach for the Court was identified in Al-Obaidi. The CM's decision as to whether there was evidence capable of amounting to gross misconduct involved a three-fold discretion, with which the Court could interfere only on the basis of Braganza principles. Accordingly in Ardron the Judge had been wrong to conclude from Skidmore that it was a question of law for the Court as to whether the findings of fact and evidence were capable of supporting a charge of gross misconduct.

214. Turning to the facts, the cases of patients B and C could never be about clinical competence and the exercise of clinical judgment. The case of patient A could involve issues of clinical competence and judgment, in respect of the significance attached to the 'swelling'; but also gave rise to conduct issues, i.e. that he cancelled the Sunday operation for reasons of personal convenience and not because of any clinical judgment; and as evidenced by the various and varying explanations he had given. In all the circumstances Dr Goode was fully entitled to reach the conclusion that the case fell into the conduct category alone. There would be no disadvantage to the Claimant in this categorisation. He could call evidence to support his case, e.g. from an consultant orthopaedic surgeon to support the clinical judgment which he claimed to have formed and thereby defeat the allegation that he had acted for personal convenience. Thus (nearly) everything advanced on his behalf in this trial could be placed before the disciplinary panel in defence of the allegations. He emphasised that the 'trigger of concern' was raised by the fact that there had been three incidents in one weekend, two of which could not involve issues of clinical competence.

215. Turning to the CI's findings, as to patient A Mrs Rose found (para.5.6) a clear divergence of evidence between the explanation given by the Claimant for cancelling the operation and the account given by Dr Saleem that the case was a high-risk emergency; that there was space in the theatre for operating on Sunday; and conflicting clinical opinion. Mr Gorton acknowledged that this did not state that the Claimant had acted for his personal convenience, but submitted that any procedural unfairness was cured by Dr Goode's further letter of 23 November which set this allegation out clearly.

216. As to patient B, the IR recorded the conflicting evidence of Dr Saleem and the Claimant as to whether he was contacted at the weekend. The case was indicative of the Claimant's inattention to what he should have been doing. As to patient C, there was clear acceptance by the Claimant that he could have taken further steps.

217. As to breach of Domain 4 'Maintaining Trust' Mrs Rose's finding was that the evidence suggested that the Claimant had not appropriately prioritised each of the three patients and that their treatment did not fully meet their needs. Her conclusions included that the evidence suggested that the Claimant's conduct had 'fallen short' of the Domain 3 and 4 guidelines. This was all sufficient for a case to answer on conduct; and gross misconduct.

218. The consequent letter of 24 February 2020 was not to be seen as containing an exhaustive account of the case against the Claimant. The supporting evidence was in the IR. As the letter stated, and consistently with the Disciplinary Policy (para.4.5) the Management Statement of Case and supporting appendices were to be sent at least 10 days before the hearing. It could not be clearer from the letter that the allegation was that the Claimant had delayed the treatment 'in a conduct way'; and which was properly capable of being described as gross misconduct.

219. It was highly relevant that none of the experts in this field (PPA/MDU/BMA) raised any issue with the letter as advancing a case of conduct, not capability, and potentially amounting to gross misconduct. Dr Lord (MDU), with his expertise, was used to taking such points; had been involved from December 2019; was present at the interview on 6 January; and by his letter of 26 March accepted that it was a case of 'conduct', and by implication that it was potentially gross misconduct. This was all supported by his advice that there was a 95% chance of dismissal. The offer in that letter was a distillation of what the Claimant had been saying in his 'Duty of Candour' statement (5 January 2020). When that offer was rejected, the BMA (Mr Carver) became involved and made an offer of resignation. In his evidence the Claimant had attempted to besmirch these representatives in order to explain the concessions which had been made. As Idu confirmed at [26(5)] the fact that the Claimant and his expert representatives had not challenged the categorisation of the allegations was a matter of weight.

220. Furthermore, even if the Court had reservations about the clarity of the allegations, the Claimant and his advisers knew what was being alleged. In cross-examination he had accepted that if the allegations about prioritisation were established they would constitute misconduct.

221. MDS having been instructed in their place, its letter of 22 September 2020 brought a change of tone and tactic. The terms of that letter led to Dr Goode's review of the 'Part 2' additional material and his consequent letter of 23 November. This included the SII report on Patient A which relied on information from Mr Anand; and the further information obtained by Dr Goode from Mr Anand. If there was any lack of clarity in the letter of 24 February, that was cured by this further letter.

222. As to its reference to want of probity, he acknowledged that neither that word nor the concept were clearly identified in the letter of 24 February, as opposed to its references to categories of Gross Misconduct. Probity was simply the 'portmanteau word' for what was alleged and was supported by the evidence. The allegation that the Claimant had acted for his 'personal convenience' was supported by the evidence of Dr Saleem and Mr Anand; amounted to 'dumping' his patients because of his pending holiday; and was the inference to be drawn from the Claimant's changing accounts of the reason for cancelling the operation of the 15-year-old patient A.

223. It was wrong to use the phrase 'charge sheet' when considering the letters of 24 February or 23 November. One aim of the MHPS was to move away from 'lawyerly formality'. The Claimant had to look at both documents, together with the evidence contained in Parts 1 and 2. The Disciplinary Policy provided for the Management Statement of Case 'detailing the allegations' to be provided on *'reasonable notice (normally 7 days)*' before the hearing. The employee's opportunity to respond was at that hearing (para.4.5).

224. As to gross misconduct, there was no basis to conclude that Dr Goode's decision that there was a case to answer on gross misconduct was irrational; and bad faith had been abandoned.

Alleged procedural unfairness

Claimant's submissions

225. The Claimant alleges that there were material breaches of the contractual procedures in that the Defendant:

(1) failed to consider the Claimant's grievance against the categorisation of the case (POC para.50(4));

(2) failed to obtain any or any appropriate clinical input into the investigation process (50(1));

(3) Dr Goode carried out a quasi-investigation in the period September-November 2020, contrary to his role as CM; and thereby included evidence not gathered as part of Mrs Rose's investigation before the disciplinary hearing (50(3) and (6));

(4) failed to investigate conduct/probity concerns; or to provide the Claimant with clear and complete details of the allegations to be faced at the hearing (50(2) and (7)).

232. In the light of the eventual supply of legible theatre lists, the claim in that respect (POC para. 50(9)) was no longer pursued.

226. As to the law generally, Ms Misra duly acknowledges the principles identified in Chhabra that, as a general rule, it is not appropriate for the Court to intervene to remedy minor irregularities in the course of disciplinary procedures between employer and employee; or to 'micro-manage' such procedures. Further the Court should be slow to interfere where the disputed issues can be sorted out and resolved within the framework of internal procedures: Gregg v. North West Anglia NHS Foundation Trust [2019] ICR 1279, CA. By contrast, the Court may intervene where there are irregularities which individually or collectively amount to a material breach of contract; and particularly where (as here) any common law damages awarded after the termination of employment might be very limited: see Chhabra at [39]. As expressed in Hendy v. Ministry of Justice [2014] IRLR 856, to be sufficiently serious for these purposes the breaches have to be such as to *'...make the continued pursuit* [of the disciplinary process] *unfair in a manner which cannot be remedied within the proceedings themselves'*: per Mann J at [49].

Failure to consider the grievance

227. Ms Misra accepts that this complaint is now academic, since the relevant grievance (categorisation) is the major subject of this trial. She submits that the Defendant should have considered the Claimant's grievance dated 25.8.20 pursuant to MHPS Part III para.9; and was wrong to refuse to do so on the basis of the exclusion of 'Disciplinary matters' from its Grievance procedure (para.3.1). That exclusion states that where the matter is excluded from the Grievance procedure, *'…the appropriate policy should be used.'* That took the matter back to the MHPS Part III para.9.

Failure to obtain any or any appropriate clinical input into the investigation

228. The MHPS required that the CI *'…must formally involve a senior member of the medical…staff where a question of clinical judgement is raised during the investigation process.'*: Part I para.12; to similar effect the HCP at 3.2.6. Mrs Rose, a retired physiotherapist, had not sought such advice. This was a fundamental breach of the contractual procedures, which could not be remedied at the disciplinary hearing.

229. The potential significance of clinical issues had been confused by the terms of the TOR which contained the implicit assumption that there had been a clinically-unacceptable delay; hence its heading and the terms of TOR (2).

230. However both Dr Goode and Mrs Rose had realised that clinical issues were potentially involved, hence Mrs Rose's 18 December 2019 e-mail question and Dr Goode's response (not forwarded to Mrs Rose): *'The delay of treatment is still part of the clinical decision-making'*. This contrasted with Ms Smith-Payne's e-mail of 4 December that the investigation: *'does not necessarily need to be clinical as the issue is in relation to conduct and failure to respond to clinical emergencies.'*

231. The result of this confused approach was a degree of incoherence in Mrs Rose's report. Thus at para. 5.6 she recorded the Claimant's account of swelling as one of the reasons for delay and that this was at odds with Dr Saleem's account of his and other opinion; and then stated that clinical opinion differs on this issue. Without appropriate clinical input Mrs Rose was unable to form an opinion on the differing views; likewise in her statement that there was evidence that the Claimant 'did not appropriately prioritise' the three patients.

232. In her evidence she had said, of these conflicting opinions, that her role was to decide on the balance of probability; and that where there were several people who agreed and one who disagreed the majority were likely to be correct. However Mrs Rose was not in a position to resolve the differing views.

Dr Goode carried out a quasi-investigation contrary to his role as CM/thereby included evidence not gathered as part of Mrs Rose's investigation before the disciplinary hearing

233. In Chhabra the Supreme Court held that one of the specific examples of serious and material irregularity was where the CM had gone outside his remit by sending matters to a disciplinary hearing which had not been the subject of investigation by the Case Investigator : *'But the procedure does not envisage that the case manager can send to a conduct panel complaints which have not been considered by the case investigator or for which the case investigator has gathered no evidence'*[32].

234. In this case Dr Goode had conducted his own investigation rather than asking Mrs Rose to open her investigation on the basis of a suitably amended TOR. Contrary to his evidence, Dr Goode was not merely clarifying matters which had been raised as gaps in the investigation by MDS in its letter of 22 September 2020. In effect he was acting as case investigator for a new case of dishonesty/want of probity; and for that purpose obtaining information from Mr Anand who was then added to the list of witnesses for the disciplinary hearing. In addition, this further investigation again had no involvement of an appropriate and independent clinician.

Failure to properly investigate conduct/probity concerns; failure to provide clear and complete details of the allegations to be faced by the Claimant at the hearing

235. None of the probity allegations were the subject of Mrs Rose's investigation. In her evidence she said that she did not recall the word 'probity' being mentioned; nor was it in the TOR.

236. The procedures required that the specific allegations must be notified to the practitioner at the time when he is advised that a CI has been appointed to carry out an investigation: MHPS Part I para.13; HCP 3.2.5. This was of particular importance if the allegations were of the gravity of a challenge to his probity.

237. The letter of 24 February provided no such allegations of want of probity. If (contrary to the Claimant's primary case) the subsequent letter of 23 November could be taken into account as the basis of the allegations, it was wholly defective. In particular the letter provided no basis for the assertions that the Claimant had acted in respect of each patient for 'his own personal convenience' rather than their clinical needs; nor for the contention that he had breached the GMP (para.68) requirement to be honest and trustworthy in all communications with patients and colleagues. Even in his evidence Dr Goode had been unable to give a clear and coherent basis for these allegations of want of probity. Furthermore none of these allegations of want of probity been put to the Claimant at any stage of the investigation.

Defendant's submissions

Failure to consider the grievance

238. The cited provisions of the MHPS said no more than that a practitioner who considered that the case had been wrongly classified as misconduct was '*entitled to use the employer's grievance procedure'*. Since the practitioner already had that right under the grievance procedure, it added nothing and was too 'vague and imprecise' to be apt for incorporation as a contractual right: cf. Hussain v. Surrey and Sussex Healthcare NHS Trust [2011[EWHC 1670 (QB) at [168].

239. In any event, even under the terms of the MHPS provision, the time to raise the grievance was when the employer made the decision on classification. The provision must be subject to an implied term that it must be used within a reasonable period of time; for otherwise it could be used to resurrect matters long expired. In this case the Claimant had made no objection to the classification until he changed advisers; and indeed had positively endorsed through the MDU without prejudice letter of 26 March. It was too late to raise a grievance 6 months after the classification decision had been

made; and when in consequence it conflicted with the exclusionary terms of the grievance policy.

Failure to obtain any or any appropriate clinical input into the investigation

240. The case always related solely to conduct; and the Claimant and his advisers had engaged with the case on that basis until he changed advisers in July 2020. Mr Javed had been allocated to be called upon by Mrs Rose if necessary; but in a case involving probity, not capability, she had not needed to do so. As the allegations involved professional misconduct, in accordance with HCP para. 3.4.5.2 the letters of 24 February and 23 November had advised that the panel would include a member who was medically qualified at consultant level and not currently employed by the Trust; and the Defendant had subsequently changed the choice of consultant following complaint on behalf of the Claimant. By the letter of 23 November the Defendant had also indicated willingness to commission a desktop independent review; and had then duly instructed Mr McEvoy to consider whether the Claimant's conduct amounted to professional misconduct and had obtained his response: HCP 3.4.2.

Dr Goode carried out a quasi-investigation/included evidence not gathered as part of Mrs Rose's investigation before the disciplinary hearing

241. As the authorities made clear, where the detailed procedures were silent or non-exhaustive on a point, the fallback position was that the Defendant was to act in accordance with its managerial discretion: see Gregg; Burn; also Al-Mishlab v. Milton Keynes Hospital NHS Foundation Trust [2015] EWHC 3096 (QB: Green J, as he then was) at [17].

242. This was what Dr Goode had done. In response to MDS' letter of 22 September, he had responded to the issues raised; the most significant of which was the complaint that Mr Anand had not been contacted. This was an act of managerial discretion against which there was no basis of challenge. The MHPS and HCP imposed no prohibition against seeking more or clarificatory evidence other than through the CI; nor any exclusion of evidence not obtained by the CI. Any such exclusion could work to the disadvantage of either side; for the practitioner if e.g. exculpatory evidence were obtained. It would be artificial to go back to the CI when it was largely an internal disclosure exercise and asking for comments on the Claimant's extensive statements and documents. The procedures do not allow the 'closing down' of the investigation in this way. All that Dr Goode had done fell within the ambit of the TOR and the IR.

Failure to properly investigate conduct/probity concerns; failure to provide clear and complete details of the allegations to be faced by the Claimant at the hearing

243. The allegations were properly investigated and particularised with appropriate clarity. As submitted, the TOR and IR implicitly and respectively raised and considered the issue of probity. If (contrary to the Defendant's primary case) there were any lack of clarity in the details of the allegations in respect of probity, all necessary clarity was provided in Dr Goode's letter of 23 November and also the Defendant's solicitors' letter of 27 November. In any event, as the Disciplinary Policy provided, the detail of allegations was to be provided in the management statement of case supplied together with reasonable notice of the disciplinary meeting: para. 4.5.

244. On a broader canvas, Mr Gorton submitted that the Claimant was seeking to pursue a capability route so as to prevent any sanction being applied to him. The aim was to trap the employer so that it could not investigate the serious concerns which it had about his probity. This was what the case was all about. If the capability route were taken, he would first have to be failed by a PPA panel for a capability hearing to be established. Based on the Claimant's evidence as to the reflection he had undertaken and the remediation he proposed, that was never going to happen. He had accepted the lessons learned in respect of patient A; and on any view the case in respect of patients B and C did not relate to capability.

Analysis and conclusions on categorisation and procedures

245. In this case the issues of categorisation and procedural fairness are inextricably linked. This is because, in my judgment, the Defendant's case against the Claimant has fundamentally changed between its presentation in Dr Goode's letters of 24 February and 23 November 2020; and because of the subsequent explicit statements by the Defendant that there is no challenge to the Claimant's capability in any respect and that the case against him is focused entirely on the contention that in the case of each of the three patients he delayed appropriate treatment for reasons of his own personal convenience.

246. In circumstances where the case is thus based solely on the probity of the practitioner, there can be no basis for anything to be referred to the capability procedure; nor therefore for the Court to make any order to require it to do so. In short, the Defendant as employer cannot be required to pursue a case which it does not in fact advance.

247. However in my judgment the fundamental change in the Defendant's case against the Claimant has involved very significant procedural irregularities which amount to a material breach of contract. This is because the case on want of probity has not been investigated by the CI; and that requirement cannot be sidestepped in the way that has occurred.

248. These conclusions have two consequences. First, for the probity case to proceed there must be fresh Terms of Reference which squarely set out the probity allegation that the Claimant put his personal convenience before the clinical needs of the three patients; a fresh investigation by a Case Investigator in accordance with those Terms of Reference; and a consequent fresh decision by a Case Manager. Secondly, that the correct characterisation of the case against the Claimant as it stood at 24 February and/or 23 November 2020 is academic.

Fundamental change of case

249. As I accept and the PPA letter of 18 November 2019 confirms, Dr Goode had a concern – in particular in respect of patient A – that the Claimant had delayed the treatment of the patients for reasons which reflected on his probity; and that this was linked to the fact that he was beginning his holiday on the Tuesday after the weekend. However I also consider that he had not excluded the possibility that there might be explanations which bore on the Claimant's clinical judgment. That is apparent from his email answer of 18 December that *'The delay of treatment is still part of the clinical decision-making'* and his evidence in cross-examination; coupled with the knowledge that Mrs Rose would be able to draw on the expertise of Mr Javed if she thought it necessary.

250. In consequence the TOR was drafted in terms which left it unclear as to whether the investigation was intended to include issues of clinical judgment. On the one hand, the very title of that document implied that the premise of the investigation was that the delays which had occurred in the treatment of each patient had no clinical justification, i.e. because they involved 'inappropriate treatment'. That premise was likewise embodied in the terms of TOR (1). By contrast, on the face of it, the terms of TOR (2)-(7) did not contain that premise. They raised open questions as to why the relevant surgery or treatment of each patient had not taken place earlier than it did; and indeed in TOR (7) had required consideration of whether the delay in each case was 'negligent'.

251. However, if the CI was being asked to investigate and consider whether there was a case to answer in respect of the Claimant's probity – and specifically as to whether he had put his personal convenience ahead of the interests of all or some of these three patients - that was an issue which needed to be unequivocally identified in (at least) the TOR. That was necessary so that both Mrs Rose and the Claimant knew that an allegation of that gravity was being made and to be investigated. The HCP/MHPS provisions make clear that the practitioner must be informed, when told that an investigation is to be undertaken, of the allegations or concerns that have been raised: HCP 3.2.5; MHPS Part I para.13. That fundamental requirement is in no way weakened by those provisions which require full details of the allegations to be provided at later stages: HCP 3.4.5.1; Disciplinary Policy para. 4.5.

252. This confusion in the TOR (1)-(7) in my judgment led to confusion in the mind of Mrs Rose as to the scope of her investigation. On the one hand, as I accept, she did not see her task as to investigate whether or not there had been clinical mismanagement by the Claimant. Her concern about this had led her to make the point which she did in her email of 18 December 2019 that it was important that the Claimant understood that she would be *'investigating delays in treatment rather than clinical decision-making'*. However, as I accept, she also properly identified the ambit of her investigation as defined by the TOR and the specific issues which they raised. In consequence, she was placed in a position whereby delay in 'appropriate management' of each patient was assumed; and yet she also found it necessary (in respect of patient A) to weigh up the conflicting clinical opinions on the decision to postpone surgery. Thus, as her IR and evidence in Court attest, Mrs Rose was to an extent drawn into consideration of the differing opinions of Claimant and Dr Saleem; an issue on which she had no relevant expertise and for which she did not draw on Mr Javed.

253. In my judgment this confusion on the ambit of the investigation then fed through into her findings and conclusions. Thus e.g. under TOR (3), these recorded the conflict of opinion as to whether there were valid clinical reasons for postponing the surgery on patient A; whereas under TOR (8) her focus was on whether there had been 'intentional' negligence (and whether the delay had caused any harm).

254. A further potential confusion arises from the terms of TOR (8) and (9) relating to the GMP Domains 3 and 4 and the use of the word 'conduct'. There is a potentially significant distinction between the use of that word in a descriptive and an evaluative/pejorative sense. The former refers simply to a person's acts and omissions; the latter to misconduct, in particular as envisaged in Part 4 of the HCP. Properly construed in the context of these TOR, I consider that the word was being used in the former, purely descriptive sense. It contains no implicit premise that the Claimant had

misconducted himself. It simply asks the CI to consider whether his acts and omissions, as investigated, may have constituted a breach of the provisions of Domains 3 and/or 4. In any event, I am satisfied that Mrs Rose interpreted the questions in that way.

255. In my judgment Mrs Rose's conclusions to an extent reflect the potential confusion in the language of the relevant TOR (8) and (9). As to Domain 4 ('maintaining trust') her statement that *'there is evidence that VK did not appropriately prioritise patients A B and C and that as a result the treatment did not fully meet their actual or potential clinical needs'* leaves it quite unclear what is meant by 'not appropriately prioritised'. I see nothing in the rest of the IR to suggest that this meant that the Claimant may have acted as he did for his own personal convenience; and in the absence of an express or implicit allegation to that effect there is no reason why Mrs Rose should have reached that conclusion. On the contrary the effect of the rest of the IR is that there may have been an error of clinical judgment in respect of patient A and failures of communication and teamwork in respect of all three patients. The effect of her conclusions under Domain 3 (communication and teamwork) is all in that latter respect.

256. In this respect it is also important to note that issues of clinical competence may engage either conduct or capability or both. This is inherently obvious but is also seen in the language of the procedures. Thus e.g. the MHPS/HCP include, within their examples of concerns about capability, out of date, incompetent or inappropriate clinical practice; but they also recognise the potential for these to extend into issues of misconduct: see e.g. the qualification in HCP para 3.5.2 *'(unless this is contrary to clear management requests made previously in which case the issue may be one of misconduct…)*; also the Disciplinary Policy Appendix 2 example of gross misconduct A17 *'Any act or omission constituting serious negligence in a member of staff's performance of his/her duties*; and the MHPS category of misconduct including *'Wilful, careless, inappropriate or unethical behaviour likely to compromise standards of care or patient safety…'*

257. In my judgment the TOR failed to identify the allegation of want of probity; and this failure is central to the present case. The TOR admittedly contained no express allegation to that effect; nor do I accept that it was implicit. If it had been implicit, Mrs Rose must inevitably have questioned the Claimant on that basis; but she did not. In consequence, and in any event, I see nothing in this IR to support a conclusion that there was a case to answer in respect of the Claimant's probity, whether by way of acting for his own personal convenience or otherwise. Dr Goode's letter of 24 February took the matter no further, since its terms depended on the IR.

258. In consequence Dr Goode's letter of 23 November in my judgment constituted a fundamental change in the case against the Claimant.

Procedural irregularities

259. In my judgment this change of case involved substantial irregularities in the investigation of the probity concerns, namely by (i) failing to have this investigated by the CI (POC para. 50(2)); and (ii) in effect doing so through the CM (POC para. 50(3) and (6). These amounted to a material breach of the Claimant's contract.

260. As I have concluded, the allegation of lack of probity and acting for his personal convenience has not been the subject of an investigation by Mrs Rose. I do not consider that this requirement can be sidestepped in the way that has occurred. As Chhabra and

the relevant provisions of the MHPS/HCP in this case make clear, the procedures draw a fundamental distinction between the roles of the CM and CI. I remind myself of the need to avoid what is described in Chhabra as the introduction of *'unhelpful inflexibility into the procedures'* [32]; but I consider this to be no answer where an allegation of this gravity has not been the subject of investigation or report by the CI. As also stated in Chhabra at [32], *'… The procedure does not envisage that the case manager can send to a conduct panel complaints which had not been considered by the case investigator or for which the case investigator has gathered no evidence.'*

261. Further, I do not consider that the importance of that independent investigation can be set aside on the basis that the material obtained and considered by Mrs Rose included evidence that might be read as providing support to an allegation that he had put his own interests ahead of the clinical needs of his patients, e.g. her interviews of Dr Saleem and Mr Shetty. In any event those interviews were after the Claimant's interview, with the consequence that nothing from those interviews were put to him.

262. I also do not accept that the fundamental requirement for the investigation to be carried out by the CI can be displaced on the basis that Dr Goode's further investigation was simply the response to MDS' letter of 22 September. Whilst that letter made a range of complaints about the conduct of the investigation, e.g. that Mr Anand had not been interviewed, it did not constitute any form of waiver or informal encouragement to Dr Goode to carry out his own further investigation; let alone into an allegation of want of probity which had not been before Mrs Rose.

263. The existing confusion is further supplemented by what appears to be misunderstanding between the instructions to and the response from the independent consultant orthopaedic surgeon Mr McEvoy. The letter of instruction (21 January 2021) seeks advice on matters of professional misconduct but expressly not as to clinical competence or judgment. By contrast Mr McEvoy's "preliminary thoughts" (27 January) include, at least in respect of patient A, considerations of optimal and sub-optimal clinical management.

264. In all the circumstances I conclude that these breaches of the disciplinary procedure are of such materiality that it would be wrong for the matter to proceed to a disciplinary hearing on the existing basis. In my judgment it is necessary for the disciplinary process to be restarted on a clear and unconfused footing as identified above

Categorisation

265. It follows that the issue of categorisation is academic. Further, there is a real element of artificiality in the whole exercise; because of the critical mismatch between Dr Goode's concerns as to probity and the terms of the TOR and consequent IR. However in view of the full argument on fact and law I will set out my conclusions.

266. As to the law, I do not accept Mr Gorton's submission that this classification is a matter of discretion for the CM subject to review only on Braganza principles; nor that any support for that contention is found in the language of the MHPS or HCP, e.g. *'It is for the employer to decide'*, *'if the case manager concludes'*, etc. As in the comparable provisions considered in Skidmore, such language merely reflects the fact that the Defendant as employer, acting through the CM, has to make the decision on

classification. However, as Skidmore held, that decision must comply with the terms of the contract; and it is for the Court to determine whether the decision did so comply.

267. In my judgment this applies equally to the decision as to whether it is a 'mixed case' involving an overlap of issues of both conduct and capability. However I accept that, once correctly classified as a mixed case, the decision on the way forward does involve the exercise of discretion which is then reviewable only on Braganza principles. In my judgment that follows from the language of the HCP (para. 3.5.2) and the MHPS (Part IV para.8).

268. On the distinct question of the categorisation of the case as 'gross misconduct', I respectfully prefer the conclusion in Ardron to that in Al-Obaidi, namely that there is an issue of law for the Court as to whether the CI's findings and evidence taken at their highest are capable of supporting such a charge; rather than an exercise of discretion by the CM and reviewable only on Braganza principles. I reach this conclusion having particular regard to the fact that this was the approach adopted by the Supreme Court in Chhabra, albeit without argument (cf. Al-Obaidi at [32]); and that it is consistent with the general approach in Skidmore, Mattu and Idu. In any event, as in Al-Obaidi, the choice between the two tests makes no difference to the result in this case.

269. In assessing the correctness of Dr Goode's categorisation in his letter of 24 February, the starting point is that this decision was based on Mrs Rose's conclusions in the IR and its appendices. That is apparent from the terms of his letter; and in any event the appropriate course under the HCP. As already noted, the letter made one change in its record of the terms of the TOR, namely the exclusion of the TOR (7) reference to the issue of whether the delay had been 'negligent'. Accordingly I approach my own assessment on categorisation on that same basis.

270. I have found it easier to start with identification of what was not (or would not have been) the correct categorisation. Thus I see no basis for the Defendant's proposition that the concerns potentially amounted to gross misconduct; and reject the Claimant's contention that the case relates solely to capability.

271. As to gross misconduct, the Defendant's case to this effect depends on the allegation that the Claimant preferred his own personal interests and convenience over the clinical needs of each of the three patients. If such an allegation were made out against a practitioner, it would plainly be capable of amounting to gross misconduct within the meaning of the general law and the MHSP/HCP provisions. However, for the reasons given above, I am satisfied that no such case was alleged in the TOR nor therefore considered by the CI or the subject of her IR. Accordingly, I see no basis on which Dr Goode could have concluded that the IR provided anything to support his conclusion that the Claimant's conduct potentially fall within one or more of the four categories of gross misconduct identified in his letter, namely A8, A17, A22 and A28; nor indeed was such as to be capable of meeting the requirement that the conduct must amount to a repudiatory breach of contract: cf. Ardron at [78].

272. In reaching that conclusion I have given due weight to the evidence that until the change of advisers in July 2020 neither the Claimant nor his expert advisers in the MDU/BMA took issue with the contention that the allegations potentially constituted gross misconduct; that Dr Lord gave advice that there was a 95% prospect of dismissal; and that settlement proposals were advanced on the basis of immediate termination.

However in my judgment the significance of this is tempered by the fact that this was part of a settlement process, and in circumstances where the Court has only seen one small segment of the privileged discussions between adviser and client. In any event, the weight to be given to the stance of the MDU/BMA or PPA is in my judgment limited by the focus which I have found necessary to place on the content of the TOR and IR.

273. It is also no answer to suggest that the Claimant 'must have known' the true nature of the allegation. In the face of the terms of the TOR, the investigation, the IR and the letter of 24 February - but also giving full weight to the settlement proposals - I see no basis to draw that inference. In any event, for the reasons given, an allegation of lack of probity must be made unequivocally.

274. As to capability, the Claimant's argument substantially depends on the proposition that issues of potential clinical negligence (Patient A) or of failures of communications and/or teamwork (Patients B and C) are necessarily matters of capability alone; and that the examples of capability issues provided in the MHPS/HCP provide further demonstration of this. I do not accept this. For the reasons given above, these are all matters which are capable of being issues of conduct, depending on the individual facts and circumstances.

275. Given the artificiality in the exercise which I have identified, this all makes for a difficult assessment. However my conclusion is that categorisation as conduct was correct. For this purpose I have given particular weight to the potential for the issues of clinical judgment, communication and teamwork to fall into the category of conduct rather than capability; and (for this purpose) to the stance of the Claimant and his professional advisers before July 2020 that this was a 'conduct' case; and to the satisfaction of the PPA with this categorisation. If I am wrong about that, in the alternative I would conclude that it was a mixed case of conduct and capability. If so, and the point were not academic, it would be necessary for the Defendant to exercise the discretion which it enjoys in a mixed case.

Conclusions on other alleged procedural unfairness

276. Given my conclusions on the fundamental problem in this case, the other allegations of procedural unfairness also become academic. I deal with them shortly.

Inadequate allegations

277. In my judgment the effect of Dr Goode's letter of 23 November was to provide a confused account of the ambit of the allegations against the Claimant; in particular because of its insistence that the allegation of want of probity had been the subject of Mrs Rose's investigation and of his consequent letter of 24 February. The effective merger of those two letters, which continued in the Defendant's solicitors' letter of 27 November left the matter in unacceptable confusion.

Grievance

278. I conclude that the Defendant's refusal to consider the Claimant's grievance was a breach of the contractual procedures. Whilst the Grievance Procedure excludes the operation of that procedure from the disciplinary process, it does not do so in respect of the anterior question of whether the relevant concern has been correctly categorised as

falling within that process, i.e. as a matter of 'conduct'. That is made clear by the provision in the MHPS which expressly applies the grievance procedure to the issue of categorisation (Part III para. 9). I do not accept that its terms are too vague or uncertain for incorporation into the contract; nor that the issue of the correctness of the categorisation is a matter to be left to the disciplinary panel.

279. Without deciding the point, I proceed on the basis of the Defendant's unpleaded implied term that such a grievance must be presented within a reasonable time. Whilst giving due weight to the lack of protest on categorisation between receipt of the letter of 24 February and MDS' letter of 31 July 2020, and to the intervening negotiations of March/April 2020, I am not persuaded that the Claimant's grievance letter of 25 August 2020 was presented too late. In my judgment it should have been considered.

Clinical input

280. As I have found, the allegations in the TOR did potentially raise issues of clinical judgment by an orthopaedic surgeon; and Mrs Rose to an extent considered that issue in respect of Patient A. Since this was outside her expertise, I consider that it was necessary for her to obtain appropriate clinical advice in that speciality, pursuant to HCP 3.2.6 and/or 3.4.2.

Exclusion

281. The pleaded allegations are that Defendant (i) at the outset in November 2019, excluded the Claimant on a false and inaccurate basis (POC para.50(10)); and (ii) wrongly maintained the Claimant's exclusion in January 2021 (para.50(11)). However in her closing submissions Ms Misra stated that she sought relief only as to the present exclusion situation.

282. As to the law, Ms Misra relies principally on the decision of the Court of Appeal in Agoreyo and the proposition that *'The crucial question in a case of this type is whether there has been a breach of the implied term of trust and confidence'*: per Singh LJ at [93]; as discussed further at [95]-[98]. The focus is on the second limb of the implied term, namely whether (in this case) the employer has acted *'without reasonable and proper cause'*.

283. Under the MHPS/HCP total exclusion from work was an exceptional step to be taken; a *'last resort'* : HCP para.3.3. In this case it had been treated throughout as the default option. No proper consideration had been given to alternatives of restriction; and in consequence the Claimant had become increasingly de-skilled.

284. As to the initial decision to exclude, the underlying reason for this was to be found in PPA's letter of 18 November 2019, recording the conversation on 13 November with Dr Goode and Dr Wiggans. This referred to historic bullying issues; and made clear that this was a part of the decision to exclude. However no such rationale was put to the Claimant when told by Dr Goode on 20 November of that decision, nor in the confirmatory letter of that date. Nor was the allegation about probity put to him. Further, aside from reference in the PPA letter to some limited discussion on the point, there was no documentary evidence to suggest that any consideration was given to the alternatives.

285. In its 18 November letter the PPA had also advised that the Defendant's confirmatory letter to the Claimant should make it clear that any representations that he wished to make in respect of either the investigation or exclusion should be made to the designated board member in the first instance: as per MHPS Part II para.20. The Defendant's letter of 20 November did not do so nor did any of the subsequent letters extending his exclusion. In all the circumstances, his exclusion from all work was disproportionate and in breach of the implied term of trust and confidence.

286. It was also in breach of the express terms of the MHPS/HCP which relate to the exclusion procedures; in particular the provisions as to the conditions for immediate and formal exclusion (MHPS Part II paras.14 and 15); and which included that the practitioner be told of the reasons why formal exclusion was the only way to deal with the case and to be given the opportunity to propose alternatives.

287. The same basis of exclusion, namely to prevent any interference with the investigation process, had been carried forward in Dr Goode's subsequent letters pending completion of Mrs Rose's investigation. Following the supply of her IR, any justification for the total exclusion was removed.

288. There followed the period when the Claimant was off sick; but on his return the exclusion was reinstated from 7 September. Dr Goode's letter of 16 September provided no rationale other than that there had been no material change in circumstances since the exclusion had been first imposed. This was repeated in his letters of and, following a further period of sick leave, 21 January 2021.

289. In his subsequent letters of 11 March and and 8 April 2021 Dr Goode gave the reason that the Claimant could not carry out clinical duties since he had not had a clinical role since October 2019. The weakness in that argument was apparent; and in any event no explanation was given as to why he could not have had a more limited clinical role, for example working under supervision or with restrictions.

290. Furthermore where the Defendant had been at pains in this trial to state that there were no issues as to his capabilities, there could be no real concerns as to patient safety nor any sensible or cogent case for complete exclusion. Whilst recognising that a period of re-skilling would be necessary, the continuing total exclusion was wholly disproportionate.

Defendant's submissions

291. As to the initial exclusion, Mr Gorton submitted that the focus must be on the Defendant (and in particular Dr Goode)'s state of knowledge at the time when the decision was made. The Claimant's case was advanced on the basis that the implicit rationale for exclusion was dysfunctionality in the Department and concerns about interference with the investigative process. However Dr Goode's evidence was clear that, having regard to these three events occurring in one weekend, his primary concern was patient safety. As PPA's letter of 18 November recorded *'You told me that given the seriousness of the present clinical concerns you would not feel able to guarantee patient safety'*. The concerns about bullying and the alleged transfer of blame to Dr Saleem and the potential risk to the conduct of the investigation were a secondary reason for total exclusion.

292. The PPA was evidently satisfied with the decision to exclude without limitation. This approval continued after receipt of Mrs Rose's report. In their letter of 20 February 2020 they endorsed the continuation of total exclusion until the panel process was exhausted.

293. In its letter of 21 July 2020, at a time when the Claimant was on sick leave, the PPA advised that if he subsequently returned from sick leave *'the exclusion should be reintroduced unless there has been a material change in circumstances which means that exclusion is no longer appropriate'*. Following the advice from Occupational Health that he was fit enough to commence a phased return to work, the Defendant concluded (and so advised the Claimant and PPA) that there was no material change of circumstances and the exclusion was reimposed. This continued; and the Claimant correctly accepted in cross-examination that there had been no material change of circumstance.

294. In cross-examination no case had been put to Dr Goode that he did not have grounds for exclusion. The decision had not been challenged in November 2019 by the Claimant, nor subsequently through the MDU and BMA. He knew that he was excluded until the process was completed, unless there was a material change in circumstances.

295. There was nothing false or inaccurate about the basis upon which the decision to exclude had been made. As to the statement (recorded in the PPA letter 18 November) that the Claimant *'... was unable to give an explanation as to why he had not managed this patient himself in a more timely manner and blamed the registrar for the clinical decision-making - you believe this to be untruthful and consider that it brings* [his] *probity into question'*, this was based on the evidence from Mr Anand: see the note from his diary which records the successive explanations from the Claimant.

296. There was likewise no basis for the challenge to the continued exclusion after January 2021; nor had any such challenge been put to Dr Goode in cross-examination.

Conclusions on exclusion

297. In considering the general issue of exclusion, I have kept firmly in mind the restrictive approach to the power of exclusion which the MHPS/HCP provides; noting in particular that it must be a 'last resort'; that alternatives must be considered; and the careful process of initial decision and regular review which is required. I also give full weight to the concerns of de-skilling over a prolonged period of exclusion such as this. However I am satisfied that there has been reasonable and proper cause for the decisions which have been taken; and therefore conclude that there has been no breach of the implied term of trust and confidence.

298. As to the first ground of challenge, I do not accept that the decision to exclude in November 2019 was made on a false or inaccurate basis. Dr Goode acted honestly and in good faith on the basis of the information which he had received. On that basis – which included the information from Mr Anand about successive explanations – he had reasonable and proper cause for his primary concern which was patient safety. There was also a sufficient basis for his secondary concern from the background of relationships in the Department, and the issues arising from the three incidents, that the investigation must not be compromised in any way.

299. If and to the extent that there were breaches of the precise detail of the exclusion procedure, in my judgment those (on the facts of this case) are minor matters which give no sufficient basis for the Court to intervene. The primary concern of patient safety on the basis of the information before the Defendant made it an unimpeachable decision to exclude.

300. As to the continued exclusion after January 2021, I accept Mr Gorton's submissions that in the admitted absence of any change of circumstances and pending the disciplinary hearing the decision to continue the exclusion was justified. The concern about patient safety remained; and regardless of the dispute over categorisation. The matter was of course further complicated by the Claimant's various periods of sick leave.

301. All that said, the whole question of exclusion evidently needs to be reviewed in the light of two interwoven and significant changes of circumstances. First, my conclusion that the existing process is flawed and that the matter can only proceed on the basis of fresh Terms of Reference and a fresh investigation. Secondly, the Defendant's clear assertion that there is no challenge to the Claimant's clinical skills or other capabilities. That said, and as the Claimant rightly acknowledges, on any view a period of re-skilling would be necessary in any event. However in my judgment these are all matters for the Defendant, not the Court, to consider afresh.

Disposal

302. In closing argument it was acknowledged by both parties that, if and to the extent that the Claimant established its case on breach of contract, the nature and extent of relief would have to be the subject of further discussion in the light of my judgment. I invite the parties to liaise for that purpose.