Michaelmas Term
[2013] UKSC 80
On appeal from: [2013] EWCA Civ 11

JUDGMENT

West London Mental Health NHS Trust (Respondent) *v* Chhabra (Appellant)

before

Lady Hale, Deputy President
Lord Kerr
Lord Reed
Lord Hughes
Lord Hodge

JUDGMENT GIVEN ON

18 December 2013

Heard on 29 October 2013

Appellant	*Respondent*
Mark Sutton QC Betsan Criddle (Instructed by RadcliffesLeBrasseur)	Jane McNeill QC Louise Chudleigh (Instructed by Capsticks Solicitors)

LORD HODGE, (with whom Lady Hale, Lord Kerr, Lord Reed and Lord Hughes agree)

1. This appeal is concerned with the operation of the disciplinary procedures for doctors and dentists in the National Health Service, which the Secretary of State for Health introduced over eight years ago. It raises an important question about the roles of the case investigator and the case manager when handling concerns about a doctor's performance.

The relevant procedures

2. In December 2003 the Secretary of State for Health exercised his powers under section 17 of the National Health Service Act 1977 to give directions called the Restriction of Practice and Exclusion from Work Directions 2003. These required all NHS bodies to comply with a document which set out new procedures for the initial handling of concerns about doctors and dentists in the NHS (Health Service Circular 2003/12). Those procedures became parts I and II of the framework for disciplinary procedures for doctors and dentists in the NHS which was agreed by the Department of Health, the British Medical Association and the British Dental Association and was issued in February 2005. By the Directions on Disciplinary Procedures 2005 the Secretary of State directed all NHS bodies in England and Wales to implement the full version of the framework contained in a document called "Maintaining High Professional Standards in the Modern NHS" ("MHPS").

3. The principal relevant innovations in MHPS were:

(1) An employing trust took on responsibility for disciplining doctors and dentists whom it employed;

(2) Doctors and dentists were made subject to the same locally-based misconduct procedures as other staff members;

(3) The same disciplinary procedures applied to all doctors and dentists employed in the NHS;

(4) The new disciplinary procedure replaced the disciplinary procedures contained in circular HC(90)9, which I discuss in paras 16 and 17 below; and

(5) There was a single process for dealing with concerns about the professional capability of a doctor or dentist, which tied in with the work of the National Clinical Assessment Authority ("NCAA"). This involved the preparation of an action plan to address the concerns about capability. But if that plan had no realistic chance of success, there would be a capability hearing before a panel.

4. MHPS recognised the importance of doctors and dentists keeping their skills and knowledge up to date. It expressed a preference for tackling concerns about the performance of a doctor or dentist by training and other remedial action rather than solely through disciplinary action. But it did not seek to weaken accountability or avoid disciplinary action where there was genuinely serious misconduct. It recognised that, where serious concerns were raised, the paramount duty was to protect patients.

5. MHPS provided that where concerns arose about a practitioner's performance, the medical director was to liaise with the head of human resources to decide the appropriate course of action. This involved the identification of the nature of the problem or concern and consideration whether it could be resolved without resort to formal disciplinary procedures. Where the concerns related to clinical directors or consultants, the medical director was to be the case manager and was responsible for appointing a case investigator.

6. It was the task of the case investigator to investigate the allegations or concerns and report within four weeks. Paragraph 12 of Part I of MHPS stated:

> "The case investigator is responsible for leading the investigation into any allegations or concerns about a practitioner, establishing the facts and reporting the findings."

It was the responsibility of the case investigator to decide what information needed to be gathered and how it should be gathered. It was envisaged that this could involve both written statements and oral evidence. The practitioners who were the subject of investigations were entitled to see a list of the people whom the case investigator would interview. The practitioners were to be given an opportunity to put their view of events to the case investigator and were to have the opportunity to be accompanied when they did so. The case investigator's report was to give

the case manager sufficient information to enable him or her to decide whether, among other things: (i) there was a case of misconduct which should be considered by a disciplinary panel; (ii) there were concerns about performance that should be explored by the NCAA; (iii) there was a need to consider restrictions on the practice of the practitioner or his or her exclusion from work; and (iv) there were intractable problems about performance which should be put before a capability panel.

7. Part III of MHPS provided guidance on conduct hearings and disciplinary procedures. Every NHS employer was to have a code of conduct or staff rules which set out acceptable standards of behaviour. Breaches of those rules were to be treated as misconduct. Issues of misconduct were to be dealt with by the employing NHS body under its own conduct procedures. Employers were advised to seek the advice of the NCAA particularly in cases of professional misconduct.

8. In 2005 the NCAA changed its name to the National Clinical Assessment Service ("NCAS") when it became part of the National Patient Safety Agency. It is now an operating division of the NHS Litigation Authority.

The Trust's implementation of MHPS

9. In March 2007 the West London Mental Health NHS Trust ("the Trust") implemented the Secretary of State's directions by introducing a policy for handling concerns about a doctor's performance (policy D4A) and by amending the disciplinary policy (D4) which it introduced in July 2001. The latter policy set out guidance on the conduct of staff in its staff charter (appendix 3 of policy D4). That guidance included as a value "Preserve Confidentiality" and stated as example behaviour the following:

> "Uphold the Trust's policies on freedom of and disclosure of information. Do not abuse knowledge. Use appropriate private locations for discussions of a personal nature and use e-mail correspondence cautiously."

10. The disciplinary policy (D4), as amended, applied to all of the Trust's employees. It stated, at para 3.1:

> "It is a fundamental principle of all disciplinary action that employers and managers must act in a way which an objective observer would consider reasonable…"

It provided that the member of staff had to be told in writing of the complaint in advance of any disciplinary hearing (para 3.6) and stated that no formal hearing should be convened until there was sufficient evidence to suggest that there was potentially a case to answer (para 3.8). In para 13 it identified misconduct which might result in disciplinary action under three categories: minor, serious and gross. Serious misconduct was defined as "misconduct … which is not so severe as to warrant dismissal but is too serious to be considered as minor". In para 13.4.1 it described gross misconduct in the following terms:

> "Some instances of misconduct/poor performance will be so serious as to potentially make any further relationship and trust between the Trust and the employee impossible."

It listed typical examples of such conduct. In January 2011, after the events which gave rise to disciplinary proceedings in this case, the Trust amended that list with effect from 28 March 2011 to include:

> "serious breaches of information governance with regard to data protection, confidentiality and information security".

The policy also set out in section 15 and appendix 5 a "fair blame" procedure which could apply "when the potential conduct or performance issues …do not constitute serious or gross misconduct".

11. Appendix 6 set out guidance for managers for investigations under the disciplinary policy. In para 1.1 it stated

> "Before disciplinary action is taken, it is essential to establish the facts through an investigation."

In para 2, it answered the question "Why is the investigation important?" thus:

> "2.1 to establish as far as practicable what has happened and why.
> 2.2 to ensure future decisions are rational and made on the basis of evidence.
> 2.3 to meet the requirement to demonstrate that natural justice has been observed.
> 2.4 to form the basis of any case presented to a Disciplinary Panel.

> 2.5 to ensure decisions made by the trust are capable of scrutiny either through an internal appeal or by an Employment Tribunal or court of law."

The appendix advised the manager carrying out the investigation on how to conduct and record interviews and on the preparation and content of the investigatory report. Para 5 stated that the investigatory officer would be required to present findings to a formal hearing "if there is a prima facie case of misconduct and their report would form the basis of their verbal presentation". In para 9 the guidance stated that the report should contain conclusions, including whether there was a disciplinary case to answer at a formal hearing. It stated that the conclusion might suggest

> "whether the misconduct (if proven) could constitute serious or gross misconduct, or whether the Fair Blame procedure should apply".

The report was to have appendices including records of witness interviews and statements (para 10). Para 11 instructed the investigatory officer to ensure that key witnesses were available for the hearing before the disciplinary panel to enable their evidence to be scrutinised by the employee and the panel.

12. Policy D4A, which related to doctors and dentists, replaced the disciplinary procedures in circular HC(90)9. It provided in section 1 that where a serious concern arose about the conduct or capability of a doctor or dentist, the chief executive would appoint a case manager, whose first task was to identify the nature of the problem and assess the seriousness of the issue on the information available. In deciding how to proceed, the chief executive was to consult the director of human resources, the medical director and the NCAS (para 1.8). Where it was decided to follow a formal route, the medical director was to appoint an appropriately experienced person as case investigator. Para 1.13 provided that the case investigator was responsible for

> "leading the investigation into any allegations or concerns about a practitioner, establishing the facts and reporting the findings".

The case investigator was charged with collecting sufficient written statements and oral evidence to establish a case before it was decided whether to convene a disciplinary panel. He or she had to keep a written record of the investigation, the conclusions reached and the course of action agreed by the director of human resources and the medical director. The case investigator did not decide on what action should be taken and would not be a member of a disciplinary panel in the

case (para 1.14). The purpose of the investigation was to ascertain the facts in an unbiased manner (para 1.17). The case investigator was to complete an investigation within four weeks and thereafter to submit a report to the case manager, giving sufficient information to enable the latter to decide, among other things, whether there was a case of misconduct that should be put to a conduct panel (para 1.19).

13. Part 3 of policy D4A provided that "Misconduct matters for doctors and dentists, as for all other staff groups, are dealt with under the trust's disciplinary policy and procedure, D4", but that the Trust was to contact the NCAS for advice before proceeding when the concerns related to a medical practitioner. Para 3.2 spoke about "alleged misconduct being investigated under the Trust's disciplinary policy". In my view, the succinct provisions in policy D4A relating to the investigation need to be read alongside the provisions relating to investigations in policy D4, and in particular in appendix 6, which I have summarised in para 11 above and which cover the same ground in more detail. If there are any inconsistencies between the two policies, D4A will govern as the policy specific to doctors and dentists.

14. Part 4 of policy D4A set out procedures for dealing with concerns about capability, such as incompetent clinical practice, inability to communicate effectively with colleagues and ineffective clinical team working skills. In short, the policy provided for consultation with the NCAS and, where possible, the remediation of any lack of capability identified in an assessment through an agreed action plan to provide education and support. Where problems of capability were so serious that no such action plan had a realistic prospect of success, the case manager, informed by the investigation report and the advice of the NCAS, would have to decide whether there should be a capability hearing before a panel (para 4.12). Such a hearing could result in the termination of the practitioner's employment (para 4.23).

15. Para 4.5 gave guidance on how to proceed where issues of conduct and capability were involved. It provided:

> "It is inevitable that some cases will cover both 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. Although it is for the Trust to decide upon the most appropriate way forward having consulted the NCAS[,] [i]n the event of a dispute the practitioner may make representations to the designated board member. The individual is also entitled to use

> the Trust's grievance procedure if they consider that the case has been incorrectly classified."

16. The new investigative procedures were materially different from those in the previous disciplinary procedure set out in circular HC(90)9. The earlier procedure involved first a decision by the chairman of a public health authority whether there was a prima facie case against the practitioner. If the chairman decided that there was a prima facie case but the facts were disputed, the authority responsible for appointing the practitioner could set up an investigating panel, normally of three persons and with a legally qualified chairman who was not an officer of the Department of Health or the authority. The task of the investigating panel was to "establish all the relevant facts of the case" (para 11). The practitioner had a right to appear and be legally represented at the hearing. A lawyer would adduce the evidence on behalf of the authority; the practitioner's lawyer would cross-examine the authority's witnesses; and the practitioner could call his own witnesses, who would be subjected to cross-examination. The investigating panel produced a report, making findings of fact, and determining whether the practitioner was at fault. The panel was entitled to recommend disciplinary action.

17. Although policy D4A used similar language to circular HC(90)9 when it spoke of the case investigator "establishing the facts", the case investigator's role is more limited than that of the investigating panel under circular HC(90)9, which could be described as quasi-judicial in nature. The latter made findings of fact after hearing evidence which would often have been tested by cross-examination. The authority then acted on the facts which the investigating panel had determined. By contrast, under policies D4A and D4 the case investigator enquires into the facts by interviewing people, and the practitioner is not able to test their accounts of events during the investigation. The outcome of the investigation is a report on whether there is a prima facie case of misconduct. Thereafter, if the case manager decides that it is appropriate, the facts are determined at a hearing before a conduct panel, where the practitioner may be represented, test the evidence of the management witnesses, and call his or her own witnesses (policy D4 appendix 8).

The events in this case

18. Dr Chhabra was first employed by the Trust as a consultant forensic psychiatrist at Broadmoor Hospital, which is a high security unit, on 3 September 2009. There was a written contract of employment dated 26 October 2009. Clause 3 of that written contract provided:

> "Whilst it is necessary to set out formal employment arrangements in this contract, we also recognise that you are a senior and professional

> employee who will usually work unsupervised and frequently have the responsibility for making important judgements and decisions. It is essential therefore that you and we work in a spirit of mutual trust and confidence."

The clause then listed several mutual obligations, including cooperation and maintaining goodwill. It was common ground that policies D4 and D4A were incorporated into the contract of employment so far as they were apt for incorporation.

19. Shortly after her appointment, problems emerged in her relationship with her clinical team. In October 2009, negative feedback from members of her team caused her line manager to have concerns about her clinical team working skills. As a result of the continued expression of concerns it was arranged in October 2010 that Dr Chhabra should undergo a 360° appraisal process. Dr Chhabra contended that her case load had been increased contrary to her agreed job plan and that she had been deprived of the support of a senior house officer and a secretary for a number of months. Her line manager, Dr Bhattacherjee, warned her that there might be a formal process if people continued to express concerns about her. In dealing with those issues her line manager took advice from Mr Alan Wishart, the Trust's associate human resources director. On 1 October 2010 a solicitor of one of Dr Chhabra's patients submitted a complaint against her.

20. On 1 December 2010, Ms Jo Leech, who was the Head of Secure Services Policy at the Department of Health and had previously worked at Broadmoor Hospital, complained that Dr Chhabra had breached patient confidentiality when travelling by train in the company of another doctor on 24 November 2010. The allegation was that Dr Chhabra, whilst seated opposite Ms Leech in a busy carriage, discussed an incident involving a patient in the secure unit and was reading a medical report on a patient whose name and personal details could be clearly identified. As a result, the Trust suspended her from work. After Dr Chhabra brought proceedings seeking an injunction against her suspension, the Trust allowed her to resume her work at another location in March 2011.

21. Meanwhile, on 15 December 2010 Dr Nicholas Broughton, the Trust's medical director, who was the case manager in relation to the concerns raised about Dr Chhabra, decided to commission an investigation into those concerns. He appointed Dr Amanda Taylor, a consultant forensic psychiatrist from another trust as case investigator. He instructed Dr Taylor to investigate the following four matters:

(1) The allegation of breach of patient confidentiality during the train journey on 24 November 2010;

(2) An allegation that Dr Chhabra had dictated patient reports when travelling on a train;

(3) The concerns about Dr Chhabra's working relationship with her clinical team; and

(4) The solicitor's complaint dated 1 October 2010.

After Dr Chhabra expressed concerns that Mr Wishart should not be involved in the investigation, solicitors acting on behalf of the Trust wrote a letter to her solicitors dated 24 February 2011 in which they undertook that Mr Wishart would take no part in the investigation.

22. Dr Taylor carried out her investigation, which included an interview with Dr Chhabra. Unknown to Dr Chhabra, Dr Taylor communicated with Mr Wishart during the investigation. In an email to him dated 29 March 2011, Dr Taylor recorded that Dr Chhabra had admitted the breach of patient confidentiality on the train journey on 24 November 2010 (allegation (1) in para 21 above) and expressed the view that "she was unlikely to make the same mistake again". More significantly, Dr Taylor sent Mr Wishart a draft of her report and Mr Wishart prepared suggested amendments to the draft. The amendments, which were extensive, had the effect of stiffening the criticism of Dr Chhabra. Dr Taylor accepted some of the suggested amendments but not others. Among those she accepted was the characterisation as "serious" of breaches of confidentiality she had described in her report.

23. In June 2011 Dr Taylor completed and signed her report. She found that Dr Chhabra had breached patient confidentiality by having patient documents clearly visible in a public environment during the train journey on 24 November 2010 and by dictating reports, which included patient sensitive information, on a train on other occasions. She recorded Dr Chhabra's admission of those breaches. Her report also recorded Dr Chhabra's unchallenged account that she had not appreciated at the time that her practice compromised patient confidentiality and that she believed that she had ensured that no other passengers were close by when she dictated the reports. Dr Taylor also reported on an allegation by Dr Chhabra's former secretary, which had not been expressly included in her terms of reference, that she had made telephone calls when travelling by train to work in which she had discussed patient information. Dr Taylor did not make any finding on the

accuracy of this allegation but recorded that there was a difference of opinion between Dr Chhabra and her secretary. In relation to the third concern (in para 21 above), Dr Taylor stated that there were difficulties within Dr Chhabra's clinical team which were issues of capability that needed to be addressed. She concluded that the fourth issue, the solicitor's complaint, did not have merit.

24. On 12 August 2011 Dr Broughton wrote two letters to Dr Chhabra's solicitors. In one, he informed her that he regarded the concerns about her team working to be matters of capability. He said that he intended to seek the guidance of the NCAS on whether an assessment was needed or whether the Trust would be justified in proceeding to a capability hearing. In the other letter, Dr Broughton stated that the breaches of confidentiality set out in the investigation report were potentially very serious allegations of misconduct which fell within para 8.4 (sic) of policy D4, and he quoted an extract from para 13.4.1 of the January 2011 revision of policy D4 (para 10 above). The charges which he proposed to put to a disciplinary panel included not only the admitted breaches of confidentiality but also (i) the allegation, on which Dr Taylor had noted there had been a conflict of opinion, that Dr Chhabra, while travelling by train, had telephoned her secretary to discuss patient-related information, and (ii) an allegation, which was not within Dr Taylor's remit and on which she had not reported, that Dr Chhabra had breached patient confidentiality by disclosing information via email to her medical protection society and legal advisers. Dr Broughton expressed the view that the charges were considered to be potential gross misconduct and that dismissal was a possible outcome of the hearing before the disciplinary panel. He also stated his view that the issues of conduct and capability were unrelated and that the conduct allegations were straightforward and discrete.

25. Dr Chhabra's solicitors objected to the charge of breach of patient confidentiality by disclosing information to her protection society and her legal advisers, which had not been the subject of Dr Taylor's investigation. At their request, the Trust agreed to instruct Dr Taylor to investigate that allegation. Dr Taylor carried out this further investigation and reported that there was no complaint to answer. As a result, on 17 January 2012 Dr Broughton informed Dr Chhabra by letter that that charge would not be pursued at the disciplinary hearing.

26. On 22 December 2011 the Trust referred the teamwork issues (the third matter in para 21 above) to the NCAS. Dr Chhabra invoked the Trust's grievance procedure to complain about the decision to deal with the breaches of confidentiality in advance of the NCAS assessment. Mr Wishart prepared the management case for the grievance hearing. Dr Chhabra's grievance was not upheld on first consideration. The panel accepted that there was a possible relationship between the conduct and capability matters but concluded that issues of capability could be presented in mitigation at a conduct hearing. It concluded that the decision to separate the conduct matters from the capability matters was

appropriate and necessary. She appealed that decision but her grievance appeal was rejected by letter dated 29 February 2012. The appeal panel concluded that it was necessary to deal with the conduct matters separately because they were discrete and needed to be determined, whatever was the outcome of the capability process.

27. On 6 February 2012 a case conference was held to consider the Trust's capability concerns. The Trust, Dr Chhabra and the NCAS entered into a tripartite agreement under which the Trust referred its concerns to the NCAS for an assessment. Meanwhile, the disciplinary process continued on a separate track. A conduct hearing was fixed for 9 March 2012, but that hearing was discharged after Dr Chhabra sought declaratory and injunctive relief from the High Court on 2 March 2012. That started the legal process which has led to this appeal.

The legal proceedings

28. On 1 June 2012 Judge McMullen QC, sitting as a judge of the High Court, granted Dr Chhabra a declaration and injunctive relief, preventing the disciplinary panel from investigating the confidentiality concerns as matters of gross misconduct under the Trust's disciplinary policy. The judge held that Dr Broughton had failed to re-assess the gravity of the charges after he received Dr Taylor's second report. The Trust had erred and had breached its contract with Dr Chhabra in treating the matters as gross misconduct for which she could be dismissed. He also held that Dr Broughton had broken the contract by referring to the conduct panel charges which were not grounded in Dr Taylor's report. The judge also held that the Trust was bound to deal with the matters through the capability procedures under para 4.5 of policy D4A. He expressed the view that, as Dr Chhabra had admitted her mistakes, the case cried out to be dealt with under the "fair blame" procedure.

29. On 25 January 2013 the Court of Appeal (Pill, Jackson and Treacy LJJ) upheld the Trust's appeal and set aside the order of the judge at first instance. The court held that policies D4 and D4A should be read together and that the applicable rules and procedures had contractual force. The Trust had a discretion whether to combine capability and conduct issues under para 4.5 of policy D4A. Use of the "fair blame" procedure was encouraged but the Trust had a power to refer disciplinary matters to a conduct panel. The case investigator's role was to establish and report the available evidence. The case manager in deciding what action to take was not confined to the findings of fact of the case investigator but could consider complaints supported by evidence reported by the case investigator, even if denied by the practitioner. The conduct panel would resolve issues of disputed fact. It was the task of the case manager to exercise judgement as to the seriousness of the misconduct, having regard to the evidence reported and findings

made by the case investigator. The central question was whether the case manager was justified in the circumstances in convening a disciplinary hearing. The court concluded that Dr Broughton was entitled to regard the breach of confidentiality as a potentially serious offence and as a result was justified in deciding to convene the conduct panel. Dr Chhabra appeals to this court.

Discussion of the legal challenges

30. The first and most significant issue is the roles of the case investigator and the case manager. The procedures, which MHPS envisaged and which the Trust has set out in policy D4A and the amended policy D4, do not give the case investigator a power to determine the facts. This is, as I have said (paras 16 and 17 above), radically different from the role of the investigating committee under circular HC(90)9. 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, the practitioner admits that she has behaved in a certain way or where there is otherwise undisputed evidence, the case investigator can more readily make findings of fact.

31. 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. The procedure before the panel enables the practitioner to test the evidence in support of the complaint and any findings of fact by the case investigator.

32. 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 (as in the former secretary's allegations) 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, such as the records of witness interviews and statements. 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. Thus I consider that the Trust was correct in acceding to Dr Chhabra's request for a second report from Dr Taylor in relation to the new allegation of breach of confidentiality in her communications with the protection society and her solicitors.

33. In reaching this view, I am in general agreement with the judgment of the Court of Appeal. I also agree with the Court of Appeal that Dr Broughton would have been entitled to take the view that there was evidence in Dr Taylor's report which could amount to serious misconduct and that he could properly have convened a conduct panel on that basis. There is no doubt that patient confidentiality is an overriding principle and is central to trust between patients and doctors (General Medical Council, *Good Medical Practice* (2006) page 5 and paras 21 and 37, *Guidance on Confidentiality* (2009), para 6). In my view the evidence in Dr Taylor's report on the matters (1) and (2), which I set out in para 21 above, was capable of supporting a complaint of serious misconduct.

34. Where I respectfully differ from the Court of Appeal is that I consider that there have been a number of irregularities in the proceedings against Dr Chhabra which cumulatively render the convening of the conduct panel unlawful as a material breach of her contract of employment. I have four concerns about the procedure which the Trust followed.

35. First, I do not think that the findings of fact and evidence, which Dr Taylor recorded, were capable when taken at their highest of supporting a charge of gross misconduct. Paragraph 13.4.1 of policy D4 speaks of conduct so serious "as to potentially make any further relationship and trust between the Trust and the employee impossible." This language describes conduct which could involve a repudiatory breach of contract: *Dunn v AAH Ltd* [2010] IRLR 709, para 6; *Wilson v Racher* [1974] ICR 428. There is no material in Dr Taylor's report to support the view that the breaches of confidentiality which she recorded, including the former secretary's allegations, were wilful in the sense that they were deliberate breaches of that duty. In my view they were qualitatively different from a deliberate breach of confidentiality such as speaking to the media about a patient.

36. Secondly, in reaching the view that Dr Chhabra's behaviour could amount to gross misconduct, Dr Broughton founded on the words added to para 13.4.1 with effect from 28 March 2011, after the incidents in this case. The list of misconduct in para 13.4.1 comprised only typical examples of what the Trust saw as amounting to gross misconduct and was not a comprehensive statement of the concept. But Dr Broughton relied on the amended provision in support of his view that the complaints might amount to gross misconduct and quoted it in his letter of 12 August 2011 relating to the disciplinary procedure (para 24 above).

37. Thirdly, I consider that the Trust breached its contract with Dr Chhabra when Mr Wishart continued to take part in the investigatory process in breach of the undertaking which the Trust's solicitors gave in their letter of 24 February 2011 (para 21 above). In particular, when Mr Wishart proposed extensive amendments to Dr Taylor's draft report and Dr Taylor accepted some of them, which strengthened her criticism of Dr Chhabra, the Trust went outside the agreed procedures which had contractual effect. Policies D4 and D4A established a procedure by which the report was to be the work of the case investigator. There would generally be no impropriety in a case investigator seeking advice from an employer's human resources department, for example on questions of procedure. I do not think that it is illegitimate for an employer, through its human resources department or a similar function, to assist a case investigator in the presentation of a report, for example to ensure that all necessary matters have been addressed and achieve clarity. But, in this case, Dr Taylor's report was altered in ways which went beyond clarifying its conclusions. The amendment of the draft report by a member of the employer's management which occurred in this case is not within the agreed procedure. The report had to be the product of the case investigator. It was not. Further, the disregard for the undertaking amounted to a breach of the obligation of good faith in the contract of employment. It was also contrary to para 3.1 of policy D4 as it was behaviour which the objective observer would not consider reasonable: Dr Chhabra had an implied contractual right to a fair process and Mr Wishart's involvement undermined the fairness of the disciplinary process.

38. Fourthly, Dr Broughton did not re-assess the decision in his letter of 12 August 2011 that the matters were considered as potential gross misconduct after he departed from the additional complaint once he had received Dr Taylor's second report. In my view he was obliged to do so under para 3.1 of policy D4: an objective observer would not consider it reasonable to fail to do so.

39. I am persuaded that the cumulative effect of those irregularities is that it would be unlawful for the Trust to proceed with the disciplinary procedure and that the court should grant relief. 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: *Kulkarni v Milton Keynes Hospital NHS*

Foundation Trust [2010] ICR 101, para 22. Such intervention would produce unnecessary delay and expense. But in this case the irregularities, particularly the first and third, are of a more serious nature. I also bear in mind that any common law damages which Dr Chhabra might obtain if she were to succeed in a claim based on those irregularities after her employment were terminated might be very limited: *Edwards v Chesterfield Royal Hospital NHS Foundation Trust* [2012] 2 AC 22 and *Geys v Société Générale* [2013] 1 AC 523, para 73, Lord Wilson.

40. I do not think that the second irregularity on its own could have justified this court's intervention. I have some doubt whether the fourth irregularity, if it were the only complaint, would in the circumstances have justified injunctive relief. I acknowledge that Dr Chhabra did not plead Mr Wishart's involvement as a ground of her challenge to the decision either at first instance or in the Court of Appeal. Had this been the only successful ground of challenge, I would have viewed it as coming too late as the Trust might have led different evidence in answer before Judge McMullen. But the categorisation of Dr Chhabra's conduct as gross misconduct is itself a sufficient ground for injunction. Further, the facts relating to Mr Wishart's involvement were before Judge McMullen, and in the Court of Appeal Pill LJ discussed them in para 62 of his judgment. Where I differ from the judge at first instance is that, like the Court of Appeal, I do not consider Mr Wishart's involvement to be a "minor" irregularity. Where I differ from the Court of Appeal, is that I do not think that Dr Taylor's acceptance of some of his suggested amendments and her good faith materially reduce the seriousness of the procedural irregularity.

41. I deal briefly with three further submissions which Mr Sutton advanced on behalf of Dr Chhabra. First, I consider that the Trust was not obliged to consider the operation of the "fair blame" procedure in appendix 5 of policy D4 (para 10 above) because the Trust was entitled to view the allegations against Dr Chhabra, if established, as constituting serious misconduct. Secondly, the Trust had a discretion under para 4.5 of policy D4A (para 15 above) whether to combine issues of capability and conduct in a capability hearing. The Trust's decision that it was appropriate to convene a conduct panel for the discrete complaints about Dr Chhabra's conduct was within its discretion. I construe the guidance in that paragraph, when it speaks of there being occasions when "it is necessary to pursue a conduct issue separately", as referring to what is appropriate in the circumstances rather than a test of strict necessity. Such a test would not be consistent with the subsequent reference to the Trust deciding upon "the most appropriate way forward". It is not necessary for me to decide whether these clauses are apt for incorporation into the contract of employment or are mere guidance. Thirdly, I consider the irregularity of the proposed inclusion of the additional complaint in the reference to the conduct panel (para 24 above) was cured by the Trust's decision on 17 January 2012 not to pursue that complaint.

42. I would allow the appeal and substitute for Judge McMullen's orders an order restraining the Trust from (a) pursuing any of the confidentiality concerns contained in the Trust's letter of 12 August 2011 as matters of gross misconduct and (b) pursuing any confidentiality concerns without first re-starting and completing an investigation under its policy D4A.