

# Report of Research on Consistency of Decision-Making

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## Executive Summary

This Report was commissioned to examine the decision-making in Case Meetings of Council members of CHRE from April 2004 and was anticipated to include:

1. An analysis of consistency of decision-making, including use of learning points, referrals to the High Court, consistency of seemingly similar cases across regulatory bodies and consistency within categories of misconduct.
2. An analysis of the typology used by CHRE staff to record different categories of cases.
3. Consideration of the advantages and disadvantages of CHRE adopting an across-the-board policy in relation to certain categories of cases.
4. The extent to which consistent outcomes (as distinct from consistent processes) are necessary or desirable, together with suggestions for how such consistency might be achieved.

For the purpose of the research the following categories were adopted:

- A. Dishonesty (4 cases)
- B. Abuse of relationships cases
  - B.1 Inappropriate examination (3 cases)
  - B.2 Improper relationship (3 cases)
- C. Child Pornography (6 cases)
- D. Performance/ competence/negligence
  - D.1 Initial incidents (11 cases)
  - D.2 Performance assessment/restoration cases (3 cases)
- E. Health (alcohol) (1 case)

Part A of the report describes the types of cases considered and the referral patterns in these categories. It found cause for concern about consistency only in relation to the improper relationship category, where one case seemed to have been regarded less seriously than might have been expected given the pattern of decisions. Performance cases were ranked by seriousness as perceived by the researcher and this ranking was consistent with the disposal of cases. There seems to have been a natural distinction between cases where there were found to be single incidents rather than systematic failures in professional competence and those of more serious misconduct or misconduct that represented a pattern of unacceptable performance. The former were

not referred, the latter were either referred or required action in the form of discussions with the regulator.

Part B of the report section considers the structures of the decisions at S 29 Meetings. Two main approaches to the decision making process could be seen. The first concentrated on public protection and the management of risk to individual patients or the general public in the future. The second focussed on the nature of the misconduct and whether the sanction applied was commensurate with that misconduct. There was also a third factor that was important in decisions, concerning the options available to the regulator. In some cases, the limited powers that had been available to the regulator were the dominant feature of the case, either in terms of whether the regulator could have acted differently or in terms of what would be the most pragmatic way of providing public protection within the available regulatory powers. One of these three factors tended to become the primary approach in each case, although it was not necessarily to the exclusion of others. Within each broad approach guidance on relevant considerations might assist consistency, but that guidance would take a different form in each case.

Part C considers whether there are any inconsistencies between the ways in which decisions by different regulators have been treated by the CHRE in S 29 Meetings. It found no reason to be concerned about the variations between regulatory bodies, but there may be limited value in comparisons given the sample size.

Parts D and E deal with questions of personnel involved in decisions and minor administrative matters.

Part F raises some persistent themes. First, the drawing of inferences from limited evidence, which is a necessary but problematic aspect of the challenges faced at S 29 meetings. Second, the principles of deterrence, which have been noted in the paperwork but do not seem to have been explored fully. Third, the use of tools to promote consistency. It is suggested that in relation to the assessment of risk, a structured approach to decisions may assist. In relation to cases that turn on the nature of the misconduct CHRE has developed tools to assess the seriousness of cases. There was insufficient evidence in the sample to draw conclusions on their use in practice, but they would seem consistent with past outcomes of S 29 Meetings. There is at this stage no clear guidance on how those tools would be used, and in particular whether they can be meaningful in the absence of some form of tariff.

The Report concludes that

- there is very little evidence of inconsistency (see above for the one example),
- two tools to promote consistency could be considered. One deals with those cases where the key concern is the management of identifiable risks to the public. Here, consistency of process is the most helpful approach. The other deals with those cases where the most important factor is properly reflecting the nature of the misconduct. The benefits of the typology of 'risk factors' that is being developed by CHRE may not be fully realised without some indicative tariff.

## Introduction

This Report was commissioned to examine the decision-making in Case Meetings of Council members of CHRE from April 2004 and was anticipated to include:

1. An analysis of consistency of decision-making, including use of learning points, referrals to the High Court, consistency of seemingly similar cases across regulatory bodies and consistency within categories of misconduct.
2. An analysis of the typology used by CHRE staff to record different categories of cases.
3. Consideration of the advantages and disadvantages of CHRE adopting an across-the-board policy in relation to certain categories of cases.
4. The extent to which consistent outcomes (as distinct from consistent processes) are necessary or desirable, together with suggestions for how such consistency might be achieved.

The work was to be completed within a budget of £3000.

## Research Method

I have reviewed the section 29 meeting notes on the 31 cases considered at such meetings during the period 1 April 2004 and 31 December 2004. I supplemented the review with an examination of the files of those cases. Detailed reading was mostly confined to the Lawyer's Reports for s 29 case meetings and the Director's recommendations to those meetings, although in some cases it was also necessary to read parts of the transcripts of the Regulatory hearings.

The analysis set at below is based on that documentation, considered in the light of the statutory framework, CRHP/CHRE published documentation on the s 29 process and the transcripts of court judgments. Clearly, the actual discussions at case meetings may be different from the formal record of outcomes and the reasons for them. Thus, in *Morrell*, *Bartlett* and *Watts* the notes of discussion at a meeting that lasted one hour and ten minutes amount only to about half a page. This report limits itself to inferences that can properly be drawn from the written records.

While I have undertaken some quantitative analysis of referral patterns, it should be noted that the numbers of cases concerned are small and variations cannot be regarded as statistically significant. Rather the analysis is offered to identify matters worthy of consideration. It should also be noted that even within the nine month period studied, changes have been made in the recording of meetings so that some earlier meetings had less full minutes and comments made on the basis of those notes have been made with less confidence.

I am grateful to staff at CHRE, especially Mike Andrews and Briony Mills for answering my queries as they arose and drawing attentions to factual inaccuracies in

the draft report. I have also benefited from being able to discuss the draft report with Julie Stone, enabling me to improve a number of areas where the draft was unclear.

## **Part A. Analysis by substantive category**

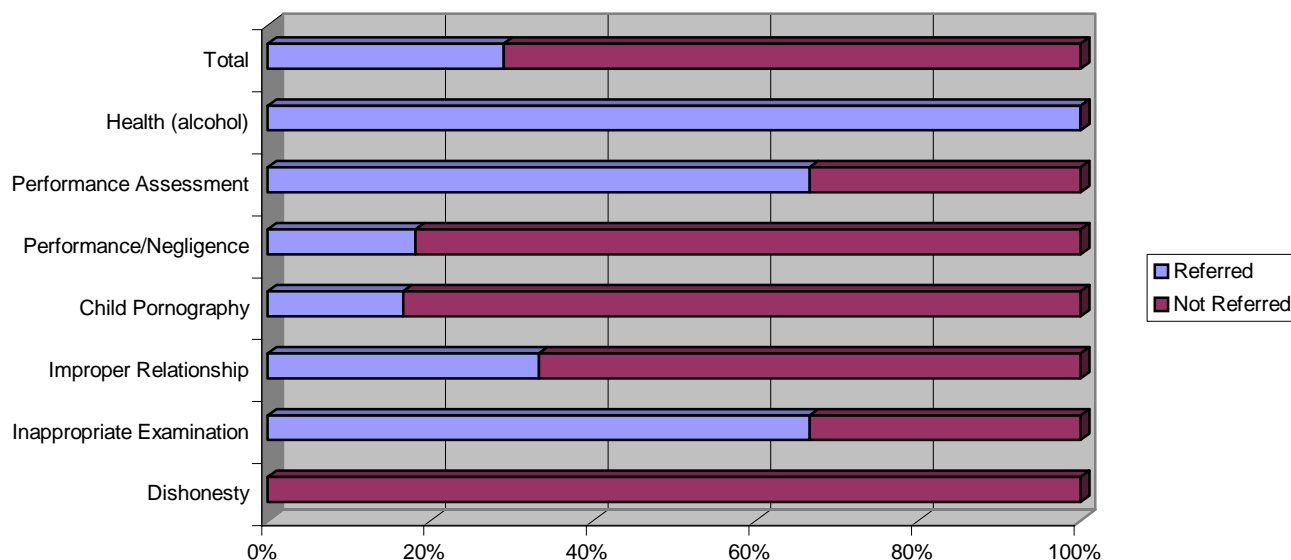
### ***Classification of cases.***

The purpose of classification of cases by CHRE officers for administrative purposes is not identical to that used in this piece of research. In order to permit analysis of consistency, it was important for the purposes of the current piece of work to seek to classify cases that had been the subject of section 29 case meetings into groups where some comparisons were possible. For broader administrative purposes, the classifications need to be used for the analysis of all referrals, creating greater numbers and more distinction between categories.

For the purpose of the research the following categories were adopted

- A. Dishonesty (4 cases)
- B. Abuse of relationships cases
  - B.1 Inappropriate examination (3 cases)
  - B.2 Improper relationship (3 cases)
- C. Child Pornography (6 cases)
- D. Performance/competence/negligence
  - D.1 Initial incidents (11 cases)
  - D.2 Performance assessment/restoration cases (3 cases)
- E. Health (alcohol) (1 case)

These categories allowed comparisons to be made between like cases, save for the health category where there was only one example in the dataset. Referral rates for these different categories are set out in Table 1, although it should be noted that the small numbers make statistical analysis of limited value. These reflect the decisions taken at the original S 29 Meetings. In two cases, one in the health category and one in the performance category, the matter did not in fact proceed to court, despite the decision at the meeting. In the former case (*Beldon*), referral proved unnecessary after the RPSGB resumed consideration of the case and the practitioner agreed to comply with undertakings. In the latter case (*Chaudhury*) it was decided not to proceed after counsel advised that the action might not succeed. This seems to have been the only example of a decision to refer being subsequently thought to have misjudged the application of the legal test. In all reported court decisions to date, judges have accepted that it was appropriate for the CHRE to refer the cases. The Table reports on the decisions at the original S29 Meetings.

**Table 1****Referral Rates by Category of Misconduct****A. Dishonesty cases**

Four cases fell into this category. In *Colagrande* the doctor had used a CV with false information in it and falsified his GMC registration certificate. *Panesar* concerned a case in which a doctor had issued 50 false prescriptions and had been sentenced to 12 months imprisonment for dishonesty. *Klentzeris* was a case of research fraud. In *Lennard* there had been serious criminal convictions, although the real risk to the public was considered to be low. It was recognised that the RPSGB had acted reasonably given its limited powers. In none of the cases was a referral made to the High Court.

**B. Abuse of relationships cases**

These all involved improper sexual activity, but were subdivided between B.1 those concerning improper examinations during clinical interactions and B.2 those concerning relationships that were formed with patients. These cases were thought to involve different considerations.

## B.1 Inappropriate examinations

There were three cases in this category. In *Bassiouny* intimate examinations had been made without clinical justification (and in the view of the S 29 Meeting with sexual intent). In *Jellet* there had been a conviction for indecent assault. Both these cases were referred because erasure was thought to be the only appropriate sanction. In *Zaheer* intimate examinations had been made without appropriate consent being obtained. The GMC's Fitness to Practise Panel imposed conditions preventing the doctor from having clinical contact with patients, save under direct supervisions and the continuous presence of a senior doctor. After considering whether deterrence required a stronger sanction, the Meeting concluded that referral was unnecessary because the conditions ensured that there was no risk to the public

## B.2 Improper relationship

This is the only area where there is some concern about consistency. There were 3 cases in this group. One of these, *Leeper*, was the subject of a court hearing within the period studied in which Collins J upheld the CHRE view that the failure of the GMC to suspend the doctor was unduly lenient (*CHRE v Leeper* [2004] EWHC 1850 (Admin)). In each of them, the practitioner had formed a sexual relationship with a patient.

In *Hamilton* (NMC) the nurse was permitted to return to practise under caution as there was perceived to be 'no significant risk to the public' and the chance of reoffending was 'minimal'. However, this case had a number of characteristics found in more serious cases such as *Leeper*.

- The relationship had begun while the man was vulnerable as a mental health patient
- Conducting the relationship had adversely affected other patients
- The nurse was said to be manipulative during the inappropriate relationship
- She failed to take steps to terminate her professional relationship with the patient and enhanced it by nominating herself as key worker

Factors seen as making it less serious were the fact that the relationship did not seem exploitative or harmful to the patient. The case might turn on the lack of a power of suspension (as indicated by Collins J in *Leeper* might be the minimum appropriate for an improper relationship in that case). The PCC of the NMC had to choose between a caution and removal from the register. Faced with that choice the view of the S 29 Meeting was that the former was acceptable.

The nearest medical case in the sample would seem to be *Harrison* (GMC) in which suspension was imposed. In that case

- The relationship commenced during a consultation
- The woman was consenting and said not to be powerless
- The doctor had made misleading statements to his partners

- There was recognition of the need to terminate the professional relationship at an early stage
- The doctor was not considered to present a risk to the public.

In a number of respects, *Hamilton's* case was more serious: there was no recognition of the need to terminate the professional relationship, the patient was more vulnerable and the nurse was manipulative of colleagues in respect of her position in relation to the patient. There is, therefore, a basis for concern that the decision in *Hamilton* is inconsistent with both CHRE practice and the expectations of the court. If the view of Collins J in *Leeper* were taken at face value, then it could be argued that as suspension is the minimum acceptable sanction, then where it is not available then erasure, or removal from the register, would be necessary. The S 29 Meeting in *Leeper* suggests that in cases of abusive relationships, at least with aggravating factors, erasure was seen as the only sufficient sanction.

This inconsistency is clearly influenced by the relative lack of sophistication of sanctions available to the NMC at the time, when compared to the GMC. However, it may also arise from assumptions about gender roles in sexual relationships (with males being considered less vulnerable than females) and/or the nurse-patient relationship being perceived as less likely to have a significant power imbalance than the doctor-patient relationship. The documentary evidence examined for this report does not allow those concerns to be tested. *It is recommended that the Scrutiny Committee consider these issues.*

### **C. Child pornography cases**

This was the second largest group of cases, with 6 examples in the sample. Of these, 1 (GDC) was referred to court, 1 (NMC) was not referred to court because it was felt the regulator had dealt with the matter appropriately, in 1 (GMC) there were concerns about the regulator's decision but these were insufficient to require referral to court and in 3 (*Morrell, Bartlett* and *Watts*, all GMC) cases there was considered to be no need to determine whether a referral was necessary as current suspensions were sufficient protection for the public. It was suggested, however, that at the very least practice should be restricted by conditions to prevent the doctors treating children.

Considerable thought has gone into the classification of child pornography cases by CHRE officers, including the production of a list of factors that could be used to assess the seriousness of cases. Proactive steps were taken to consider a consistent approach to these cases, including a meeting held with the GMC (11 May 2004).

In the three cases in which case meeting decisions were made only one, *Fleischmann* (GDC), was referred to court. The points stressed were that some of the pictures were of the most extreme level, and the Probation assessment was of a medium risk of re-offending. Factors that caused concern for the future were the risk of children attending his surgery and that the depression that provided the context of the offence did not appear to be a 'one-off situation' and could reoccur. While most of these issues concerned risk in the future, the decision of the High Court expressed some

concerns about such an approach (which it identified as having been taken by the GDC not the CHRE) if it was limited to risks to patients (*CHRE v GDC (Fleischmann)* [2005] EWHC 87 (Admin)). This is considered further below.

In *Ruthven* (GMC) conditions were accepted as 'lenient but not unduly lenient'. The focus was upon assessment of the direct risk to children presented by the doctor concerned in the future. The detailed conditions imposed by the GMC related to ensuring that he could not come into contact with children during his practice. However, there were also features of severity:

- The images were mostly but not exclusively of the less severe categories;
- Intentional purchase on two occasions
- Questionable insight

In *McKenna* (NMC) the facts were considered 'not sufficiently serious that public confidence in regulation and the reputation of the profession would be undermined as a result of the PCC's decision'. Factors indicating that the misconduct was at the lesser end of the scale were that

- the nurse was not working with children,
- the offensive material had been accessed only once,
- the images had not been downloaded
- the access had been at home not at work
- the nurse was seeking help from his GP, priest and psychosexual counsellor.

These cases can be seen as consistent both in terms of the severity of the misconduct (focussing on the past events) and also in relation to future risks. In the case referred to court the images were more extreme, the risks in the future more worrying and the steps taken by the regulator to manage them less effective.

The only aspects of the case that seem significant in terms of the three different professions would be the concern in *Fleischman* that children might visit his surgery. This raised risks similar to those with a general medical practitioner but less significant in relation to those working in a structured team environment such as a hospital where greater supervision is possible. In both the cases considered but not referred, the knowledge of the employer of the history was seen as a significant factor in lowering the risk.

#### ***D. Performance/competence/negligence***

Performance cases were those where the concern arose out of deficient/poor professional competence rather than intentional wickedness. The category is subdivided into (1) those cases where the S 29 Meeting needed to consider whether a decision on an initial complaint relating to performance had been appropriate and (2) cases where the regulator had considered whether return to practice was acceptable following more detailed assessment of a period of conditional practice. In relation to the former category, the issue may be how serious the misconduct was, but in the



latter it will necessarily concern future risk. In cases in the second category, the S 29 Meeting notes may not even indicate what the original concern was because focus was (properly) on current public protection (e.g. *Mahmomedaly* and *Mehrotra*).

## D.1 Initial incidents

There were 11 cases in this category, 8 arising from the GMC, 2 from the RPSGB and one from the GCC. Two were referred to court. Two more might have been referred to court, but working with the regulator was seen to offer more effective public protection.

The best measure of consistency in this category would seem to be the correlation between the seriousness of the initial incident(s) and the sanction. Table 2 seeks to rank the 11 cases in accordance with their perceived seriousness. At the most serious end of the spectrum is the *Mulhem* case where a court had found that the doctor was guilty of manslaughter through gross negligence of a patient in his care and where there had been other serious 'offences against the person'. The *Southall* case, where conditions designed to protect the public from over zealous accusations of child abuse were disregarded by the doctor in question, was judged by the author of this report to be the next most serious. In both those cases the S 29 Meeting found that only erasure would suffice. In *Jarman* erasure might not have been necessary but the practitioner's application for voluntary erasure placed the public protection issues beyond doubt.

Neither of the pharmacy management cases resulted in referral to court. However, each one was thought to raise concerns about the regulatory practice. In *Mitha* there was a pattern of errors over at least two years. In *Evans* there was a pattern of errors, lack of insight into the weakness of his practice and generally an inadequate deterrent message to practitioners. The main rationale for decisions in these cases was the creation of an effective dialogue with the RPSGB. This was thought to be a better way to manage risk to the public than referral.

The other cases related to single incidents and seem to have been treated consistently. The apparent difference in treatment of lack of consent probably relates to the different disciplinary standards. The GMC test is of 'serious professional misconduct', indicating that it is possible to find misconduct that is insufficiently serious to attract an adverse finding or sanction. In that context it is understandable that lack of consent might not lead to a finding of serious professional misconduct in all circumstances. The GCC test is 'unacceptable professional conduct' without a threshold of seriousness. This would explain the apparent differences between *Simonet* and *Rennison* at the regulator level and the similar decision at the CHRE S 29 Meetings. It should be noted that *Zaheer* (GMC) was also a lack of consent case, but it involved intimate examinations and resulted in conditions being imposed (see above). The *Simonet* file indicates that one of the CHRE officers did not think court action could succeed but suggests an indicative sanction that treating without consent and failing to keep records should usually result in at least the imposition of conditions. However, the notes of the S 29 Meeting do not record any discussion of this point.

**Table 2**

| <b>Case</b>      | <b>Incident(s)</b>   | <b>Regulator's Sanction</b>                                | <b>S 29 Meeting Decision</b>                           |
|------------------|--|--|--|
| <i>Mulhem</i>    | Manslaughter and serious domestic violence                               | Suspension   | Referred, erasure considered only appropriate sanction |
| <i>Southall</i>  | Improper accusation based on inadequate evidence in breach of conditions | Conditions   | Referred, erasure considered only appropriate sanction |
| <i>Jarman</i>    | Alleged inadequate treatment   | Voluntary erasure  | Not referred   |
| <i>Mitha</i>     | Pattern of errors over at least two years                                | Reprimand  | Not referred because taken up with regulator           |
| <i>Evans</i>     | Pattern of errors, lack of insight                                       | Reprimand  | Not referred because taken up with regulator           |
| <i>Simonet</i>   | Treatment without consent  | Admonishment   | Not referred   |
| <i>Renninson</i> | Single failure to obtain consent   | Not guilty of serious professional misconduct, no sanction | Not referred   |
| <i>McCallum</i>  | Failure of supervision   | Not guilty of serious professional misconduct, no sanction | Not referred   |
| <i>Gillett</i>   | Single incident of poor autopsy practice                                 | Not guilty of serious professional misconduct, no sanction | Not referred   |
| <i>Bee</i>       | Single failure in death certification                                    | Not guilty of serious professional misconduct, no sanction | Not referred   |
| <i>Hora</i>      | Single inadequate examination  | Not guilty of serious professional misconduct, no sanction | Not referred   |

It can be seen that this ranking is consistent with the disposal of cases in S 29 Meetings. There seems to have been a natural distinction between cases where there were found to be single incidents rather than systematic failures in professional competence, and those either of more serious misconduct or of misconduct that represented a pattern of unacceptable performance. The former were not referred, the latter were either referred or required action in the form of discussions with the regulator.

## **D.2 Performance assessment/restoration cases**

There were three cases in this category. In *Chowdhury* the S 29 Meeting identified significant concerns about public protection that remained outstanding and resolved to refer the case to the High Court. This was not acted upon following counsel's advice that it was probable that the court would regard the decision as lenient but not unduly so. In *Mahomedaly* referral was agreed because insufficient undertakings had been given by the doctor to protect the public adequately. These were forthcoming after the S 29 Meeting decision. Existing undertakings were found to be sufficient to protect the public so that no referral was necessary in *Mehrotra*.

## **E. Health (including alcohol/drug abuse)**

Only 1 case (*Beldon*, RPSGB) came into this category, concerning alcohol abuse. It is classified here as 'health' because it seems likely that if there had been a health procedure available to the RPSGB it would have been seen as the most appropriate mechanism for public protection while giving the pharmacist the best opportunity to rehabilitate himself so as to become fit to practise once more. The case meeting resolved to refer the matter to the High Court, apparently as a tactic to encourage the RPSGB to use its powers more proactively to ensure more robust protections for the public were put in place. The decision to make a referral to court served in itself to be sufficient incentive to persuade the pharmacist to agree to conditions, at a resumed hearing, that provided the necessary protection. Consequently, it was not necessary to implement the decision to refer to the High Court.

There are some features in common with performance cases, in that what was necessary was a framework for ensuring safe practice. However, it is suggested that it is likely that health cases will come through in the future so that a separate category is appropriate.

## **Part B: Analysis by approach to decision making**

This section considers the structures of the decisions at S 29 Meetings. Two main approaches to the decision making process could be seen. The first concentrated on public protection and the management of risk to individual patients or to the general public in the future. The second focussed on the nature of the misconduct and whether the sanction applied was commensurate with that misconduct. There was also a third factor that was important in decisions, concerning the options available to the regulator. In some cases, the limited powers that had been available to the regulator were the dominant feature of the case, either in terms of whether the regulator could have acted differently or in terms of what would be the most pragmatic way of providing public protection within the available regulatory powers.

One of these three factors tended to become the primary approach in each case, although it was not necessarily to the exclusion of others. If the key issue were identified early in discussions, then meetings could possibly be more clearly focussed on the most appropriate approach. It is also apparent that within each broad approach guidance on relevant considerations might assist consistency, but that guidance would take a different form in each case.

### ***A. Consideration of public protection in the future.***

In a number of cases, s 29 meetings found it unnecessary to consider whether decisions were unduly lenient because the referral decision turned on future risk to the public. Once the Meeting was satisfied that there was not a significant outstanding public protection issue, it concluded that referral to court was unnecessary. This seemed to be the main rationale behind the decision in 14 cases where the matter was not referred to court and 3 cases where it was, representing 55% of the total sample where the decision turned on risk assessment.

Under this approach, the principal question was whether there were outstanding matters that indicated that the public would remain at risk from the health professional despite the regulator's decision. Key issues under this approach were therefore (a) the nature of the risk and (b) whether the regulator's decision had adequately managed it. These issues were not presented in a structured way in lawyers' or directors' reports to the meeting or in the notes made. A more explicit consideration of these two issues could assist Meetings.

#### **A.1 No current risk**

The S 29 Meeting for three of the child pornography cases (*Morrell, Bartlett and Watts*) were resolved by a finding that as the doctors concerned were suspended, there was no current public protection that required referral to court. It was therefore not necessary to consider leniency issues in those circumstances (Notes paras 6, 7 & 6 respectively). In *Klenteris* the absence of public protection issues precluded the need to determine whether the decision was unduly lenient (Notes Para 13).

In *Harrison* some issues relating to leniency were explored, but it was felt that others need not be given detailed consideration once the meeting was satisfied that there was no risk to the public (Notes Para 19). In *Rennison* there was found to be no need to consider separately whether the decision was unduly lenient or one which should not have been made (Notes Conclusions d). Similarly in *Hamilton* (Notes Para 17), and *Colagrande* (Notes Para 32) the absence of the need for steps to protect the public made further consideration of undue leniency unnecessary. No significant risks to the public were found in *Hora* (Notes Conclusions b) or *Simonet*.

In *Panesar* (Notes Para 4) the lack of direct evidence of risk to the public meant that reservations about the doctor's insight were outweighed.

In *Zaheer*, where intimate examinations had been made without appropriate consent being obtained, the S 29 Meeting considered whether deterrence required a stronger

sanction than conditions that the doctor concerned did not have clinical contact with patients, save under direct supervisions and the continuous presence of a senior doctor. However, the fact that the conditions ensured that there was no risk to the public meant that no referral was necessary. The public protection issue prevailed over considerations of the nature of the misconduct.

Although not the main consideration, some aspects of risk were considered in *Lennard* and the main reason for pursuing *Mitha* and *Evans* with the RPSGB rather than making a referral to the High Court was that this was thought to offer greater protection to the public than litigation.

## **A.2 Risk adequately managed**

In *Mehrotra* it was unnecessary to consider undue leniency because an undertaking given by the doctor was found to provide the necessary public protection. In *Mahomedaly* the key issue was also public protection. The rationale for referral of the case to court was the failure of the doctor in question to provide formal undertakings not to seek employment outside of his competence and to notify all employers of this first undertaking. In fact a court hearing proved unnecessary, because faced with the referral to court, the doctor produced the required undertakings and reimbursed the Council's costs in respect of the referral.

## **A.3 Risk inadequately managed**

In one case, it was consideration of public protection issues that determined that a referral should be made. In *Jellet* (an indecent assault case) the meeting concluded that the physiotherapist represented a danger to patients, although the ability to make an assessment of this was compromised by the limited information made available to the CHRE by the regulator (Notes Para 6). Given the seriousness of the misconduct, the meeting would have needed to be satisfied that there were sound reasons to find that there was no risk. Without such evidence, whether because there was none or because it had not been made available to the CHRE by the Health Professions Council, it had to be presumed that there remained a risk. While the nature of the misconduct and the need for a sanction to deter others was a significant factor in the decision, most of the factors recorded in the notes are concerned with assessing risk and it was the continuing risk that led to referral to the High Court.

Similarly in *Beldon* it was the risk to the public presented by the pharmacist's alcoholism that led to the decision to refer the matter to court. Subsequent to the decision, litigation was avoided by agreement with the RPSGB to manage the risk through the imposition of conditions with the pharmacist's consent.

The S 29 Meeting in *Chowdhury* found that referral was necessary because the public was inadequately protected. However, counsel advised that the prospect of success was not high and the case did not proceed.

It should be noted that the judgment of in *CHRE v GDC (Fleischmann)* [2005] EWHC 87 (Admin) raises a challenge to this type of analysis based on risk management, in that it suggests that one of the errors made by the GDC in that case was to concentrate only on the risks to patients to the exclusion of risks to the wider public flowing from the nature of the misconduct (see Para [73]).

## **B. Consideration of nature of misconduct.**

There is evidence in a number of cases of an approach that sees the most significant issue as the nature of the misconduct, and the sanction required to reflect its seriousness and deter other practitioners from behaving in the same way. This was reflected in the comments in *Bassiouny*, a sexually inappropriate examination case (Notes Para 20). The S 29 Meeting indicated that erasure was the minimum appropriate sentence (Notes Para 25). In *Leeper* the need for general deterrence in cases of abusive relationships, at least with aggravating factors, was seen as sufficient to justify referral to court. Erasure was seen as the only sufficient sanction. In *Mulhem* the manslaughter of a patient through gross negligence was found to require erasure, at least when coupled with domestic violence. Similarly *Southall* was found by the S 29 Meeting to require erasure, given that conditions had proved ineffective and there was clearly no acceptance that the doctor had acted wrongly. In *Jellet* the Meeting felt that restoration to the register was wrong in a case where there had been a conviction for indecent assault because of the need for deterrence for offences of this kind and for public trust and confidence to be maintained (notes Para 29). Some consideration was given to similar arguments in *Zaheer*, although the main concern was public protection. In this category of case, there is a powerful argument that indicative sanctions are a valuable tool as the S 29 Meetings indicated that the appropriate sanction was dictated by the nature of the misconduct.

Such an approach seems to find favour with the judiciary. In *CHRE v GDC (Fleischmann)* [2005] EWHC 87 (Admin), a child pornography case, Newman J suggested that the case of *R v Oliver* [2003] 1 Cr. App. R. 463 and its indications of severity should be considered by disciplinary panels (Para [63]). He stated that

The Committee's decision to suspend for twelve months is wrong because it is plain that it could not have properly appraised the nature and gravity of the conduct involved in the criminal proceedings. In my judgment the decision is manifestly inappropriate having regard to the conduct and the interests of the public. (Para 70).

Similarly, the approach of Collins J in *CHRE v Leeper* [2004] EWHC 1850 (Admin) was based on consideration of the nature of the offence. He found that suspension was the least serious sanction that could have properly have been used in the case, which concerned an exploitative sexual relationship with a vulnerable patient for the gratification of the doctor. This is consistent with *Harrison*, where suspension was considered sufficient given the lack of further public protection issues, but possibly at variance with the decision in *Hamilton* (see the discussion above).

If the key issue is the nature of the misconduct, it may also be necessary to consider whether there are factors that either mitigate or aggravate the offence. CHRE officers had produced a list of relevant factors in this respect for child pornography cases. It was not clear from the documentary records of S 29 Meetings how this was used, but no inconsistency with the approach was detected.

Two factors relating to the seriousness of misconduct were noted in the papers; considerations of harm to patients and insight. The former is different to considerations of future harm in that it seeks to assess the impact of misconduct on patients in past, as an aspect of the seriousness of the offence, not to consider whether recurrence is likely. The latter may be relevant to future risks as well to as an assessment of the seriousness of past wrongs.

### **Harm to patients**

There is some evidence that Meetings considered whether patients had in fact been harmed, or there was merely a risk of this (e.g. *Colagrande* (Notes Para 23). In *Panesar* (a dishonesty case) it was noted that there had been no personal gain and that there was no evidence of harm to patients. In *Klenteris* lack of financial motive or large scale or systematic fraud and the fact that the misconduct had not had a significant impact on clinical care were noted (Notes Para 5), although the decision not to refer was taken on the basis of lack of risk to the public.

### **Insight**

A further relevant factor in this type of analysis is the degree of insight, remorse shown by the practitioner and the extent to which they have taken steps to improve their practice. Where these factors are present they are thought to mitigate the offence (*Gillett, Rennison, Jarman*). Where a practitioner is unrepentant this is thought to exacerbate the offence (*Southall*). This approach is consistent with sentencing practice in the criminal courts and can also be justified as an aspect of risk management on the basis that insight and remorse reduces the future risk to the public.

Since the period covered by this research the Council has considered criteria for a range of case types. It works on a similar basis to these factors in that it identifies features of misconduct, organised in various categories, that serve to indicate whether it should be regarded as more or less serious. It is not clear how it is intended to use these criteria (for example whether as a basis for scoring or as a checklist of relevant considerations).

### ***C. Consideration of the regulator's options and processes.***

In some cases, the Meeting's deliberations were shaped by factors relating to the specific regulator in question. There were three such circumstances. It was sometimes in relation to the options available to the Regulator. The Meeting needed to consider

whether the action taken had been appropriate given the limited powers that were available. In such cases, comparisons with other decisions on the basis of public protection and the nature of the misconduct in question would have been of limited help because the Regulator in question was not faced with the same range of sanctions and powers as others dealing with similar matters. There were also cases where consistency with indicative sanctions set by the regulators to govern their specific profession were significant for S 29 Meetings. Finally, there were cases where the S 29 Meeting needed to look closely at the judgments made by regulators in relation to the specific case in order to see whether they were self-contradictory or otherwise illogical.

### **C.1 Regulatory powers**

In *Hora* one of the reasons for non-referral was that no other sanction would have been appropriate (Notes conclusion c). The reasoning behind this is not apparent from the notes. The finding of the GMC was that the doctor was not guilty of serious professional misconduct in relation to the single incident (in fact two incidents on the same day in relation to a single patient). It is reasonable to infer that the rationale behind the conclusion drawn at the Meeting was that even if a finding serious professional misconduct had been made it would have been inappropriate to issue a sanction more severe than a caution. If this was the case, it might have been possible for CHRE officers to identify this without convening a meeting. However, in *Hora* itself there were further issues that would have made it inappropriate to filter the case out on this basis (see the section below on drawing inferences from limited evidence).

In *Lennard* the meeting raised considerable concerns about the case, but accepted that the RPSGB was faced with a choice between only two options, restoration and non-restoration. As there was no power to place conditions on restoration, the Society was entitled to opt for restoration. The implication of the meeting notes (Para 13) is that had there been a power to impose conditions on the pharmacist's practice, then the meeting would have expected the Society to do so. As indicated above, there may have been a similar issue about the limitations of the sanctions available in *Hamilton* (NMC).

There is some indication in *Panesar* that the fact that extension of conditions could not be used as a punishment (as the criminal sentence exhausted the punishment, as opposed to protection, issues). The decision in *Taylor v GMC* [1990] 2 All ER 263 on a similar point was noted.

### **C.2 Indicative sanctions**

In *Klenteris* the file indicates that CHRE Officers had referred to the GMC indicative sanctions, which regarded research misconduct as serious and discussed it in the context of erasure. There is no indication in the notes that the S 29 Meeting considered this issue, although the indicative sanctions were put before the Meeting.

The GMC's indicative sanctions were used as a guide by the S 29 Meeting in *Mulhem* as a tool to identify the test for whether suspension was too lenient – were the



offences ‘fundamentally incompatible with continuing to be a registered doctor.’ If they were, as the panel found, then under the GMC’s indicative sanctions suspension was inadequate. While this case was discussed using the internal consistency approach it is hard to see how it would be justified in the eyes of the public for CHRE to treat similar cases from other regulators as requiring a lesser sanction.

### **C.3 The internal logic of decisions**

In *Bassiouny* the Meeting considered that the regulator’s decision was inconsistent with its own findings. The risk to the public must have been thought to be considerable because of the immediate suspension of registration that had been ordered. It was then inconsistent with this assessment of risk not to erase him, particularly given the indicative sanctions guidance.

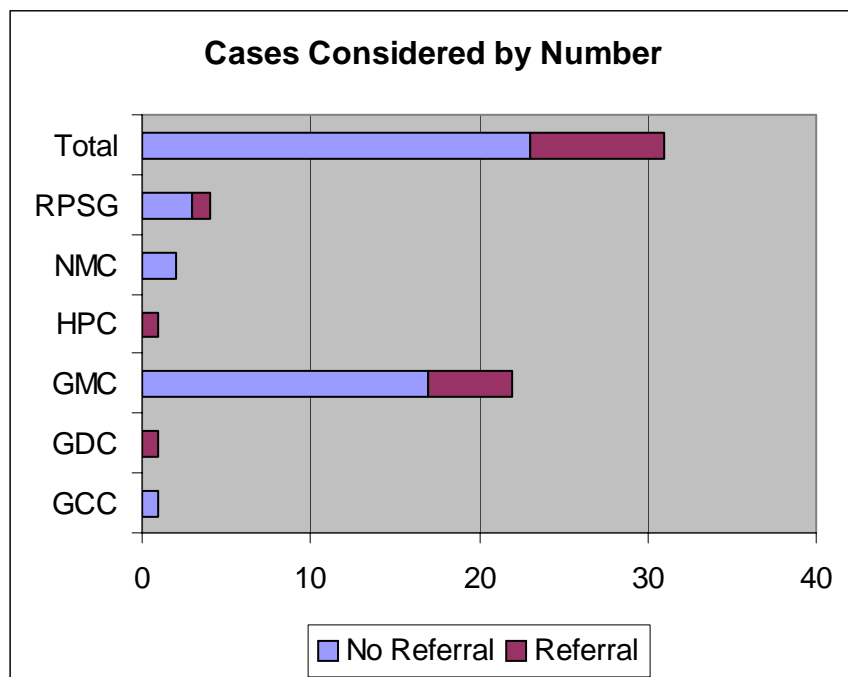
## **Part C Analysis or referrals according to regulator**

This section considers whether there are any inconsistencies between the ways in which decisions by different regulators have been treated by the CHRE in S 29 Meetings. Apparent differences in outcome may be explained by a number of factors, for example:

- The different working patterns between professions, in terms of opportunities for improper conduct or limited supervision or governance controls;
- By different options between regulators making a decision reasonable which would have been unreasonable had wider powers been available;
- The availability of pragmatic solutions such as the willingness of the practitioner to give undertakings or accept conditions

### ***Statistical pattern of s 29 referrals***

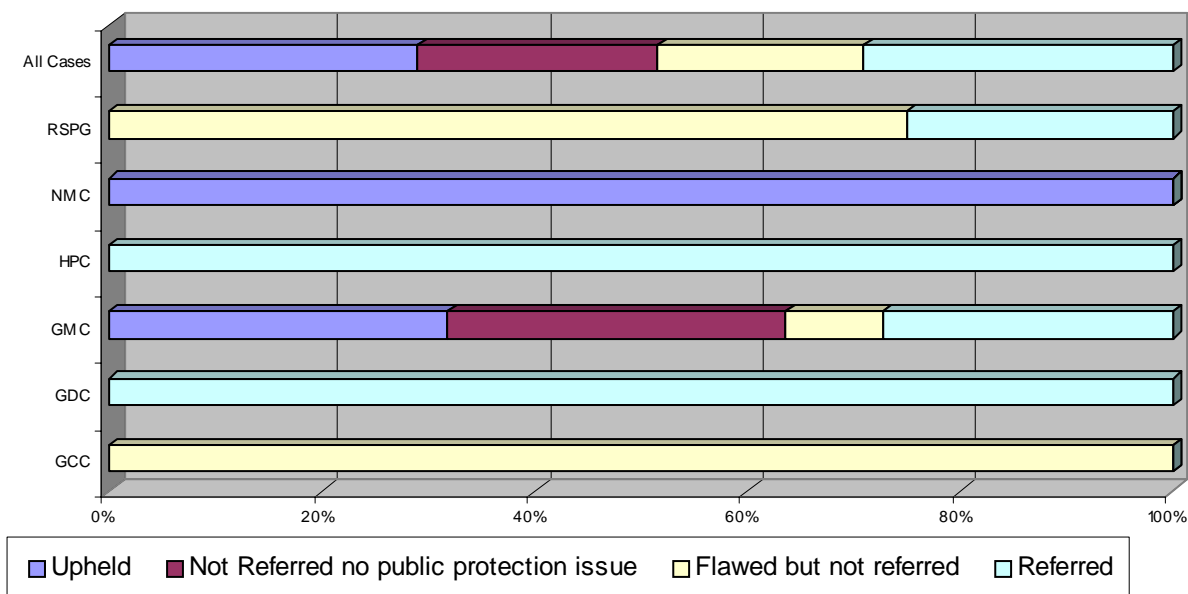
Over two thirds (22 of 31) of the cases considered at s 29 meetings concerned the GMC. The numbers concerning other regulators were very small. It is therefore important not to read too much into statistical patterns. The outcomes in terms of either referral or non-referral appear in Table 3

**Table 3**

The pattern of disposals considered in terms of this binary division masks a number of factors. It was found helpful to distinguish between four categories of decision. In the first category of case, non-referral was because the regulator's original decision was upheld by the S 29 meeting as appropriate. In the second category of case, there were no outstanding public protection issues and no judgment needed to be made about the merits of the regulator's decision. In the third category of case, there were thought to be flaws in the regulator's decision, but that these were insufficient to require referral to court or were capable of being dealt with more effectively outside of litigation. In the fourth a decision to refer was made at the S 29 meeting.

It could be suggested that the first two categories represent a positive assessment of the regulator's response to the case and the last two indicate concerns, although only the final category indicates such serious concerns that a referral to court was necessary.

In order to consider whether there is any evidence of differential treatment between regulators the outcomes of S 29 Meetings were considered against these categories. Table 4 sets out the proportions of cases for each regulator. This revealed a number of interesting features of the cases.

**Table 4****Referral Rates by Regulator**

While the GMC provided the most cases, in relation to the GMC s 29 Meetings were more likely than on average to be satisfied that the regulator had either made the right decision or had dealt with any current public protection issues (so that the leniency of the decision did not need to be considered). Only the NMC, with only two cases - both upheld - was more likely to be found to have made the right decision.

A significant feature of the GMC cases is the ability to manage the public protection issues through the use of suspension and conditions on practice. The non-availability of such powers to some regulators reduces the sophistication of the regulatory system to protect the public and sometimes forces a choice between sanctions that appear either too lenient or too harsh for the particular circumstances.

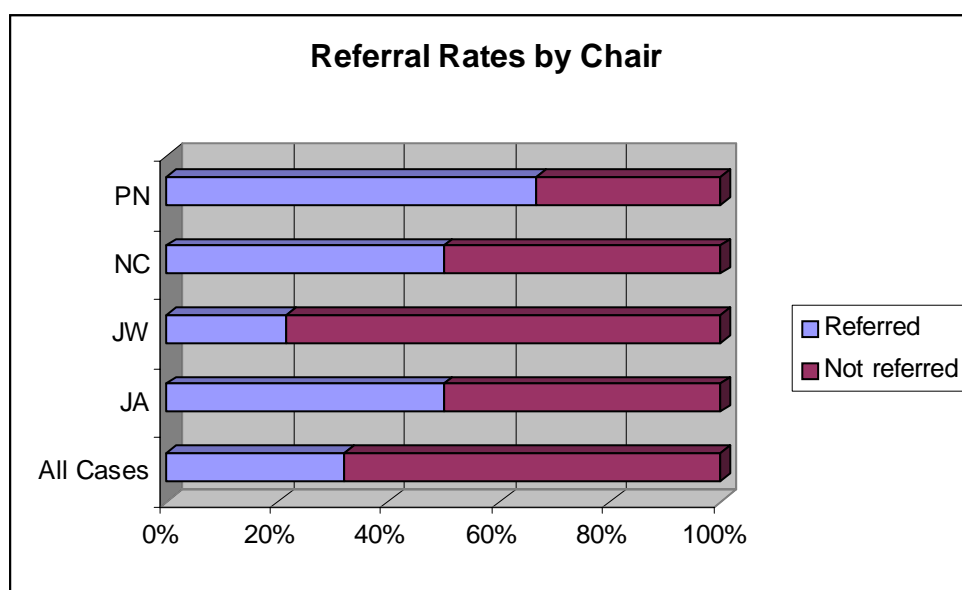
While the GCC and three of the RPSGB cases were not referred to court, in all the cases considered by S 29 meetings in relation to those regulators the decisions were regarded as flawed. In relation to three of the RPSGB cases, the Meetings resolved to take a pragmatic approach to public protection through working with the regulator rather than referral to court. It is not entirely clear from the meeting notes whether in the absence of this possibility a referral would have been made, but this seems likely from the wording of the notes on *Mitha* and *Evans*.

There seems no reason from this analysis to be concerned about the variations between regulatory bodies, but there is limited value in comparisons when the numbers of non-GMC cases are so small.

## Part D: Personnel Issues

The vast majority of section 29 Meetings (23 of 3) were chaired by the Chair of CHRE. Three other CHRE members chaired meetings (PN chaired three such meetings and JA and NC chaired two each). While proportionately it appears that meetings chaired by the more experienced s 29 Meeting chair were less likely to lead to referral, the numbers of meetings chaired by others are so small that this is not thought to be significant and no discrepancies of approach were detected.

**Table 5**



## Part E Administrative Matters

The files were generally in good order with no missing information identified. However, a few observations can be made relating to possible administrative improvements.

The notes of s 29 case meetings are mostly identified by name and it might be helpful also to include the CHRE case number to ensure that documents can easily be placed and anonymised if necessary. To date there have been no referrals with the same surname, but were this to happen there would be a risk of confusion.

In some meeting notes criminal law terminology such as 'sentence' is used. This may not be helpful as it could be misunderstood as principally concerned with punishment rather than public protection.

In some of the meeting notes there was a lack of clarity on who attends and who is on panel taking decisions. This could lead to criticism that officers had

too much influence on decisions. No evidence was found that this was the case but clearer record keeping would protect the Council from such criticism. It would seem entirely appropriate for officers to participate in discussions to assist panels in taking all the relevant factors into account, but decisions should be taken by the members of the panel.

In one case (*Colagrande*), the meeting panel consisted of only two persons. While this is provided for under the CHRE procedure, it is not the normal process and it might be advisable for the notes to indicate why the smaller panel was appropriate by reference to the relevant parts of the procedures.

## **Part F Issues for consideration**

During the analysis of the files, three other issues affecting decisions were identified that the Scrutiny Committee might wish to consider.

### ***Inferences from limited evidence***

In a significant number of the cases, Meetings were required to draw inferences that were important for their deliberations from limited evidence. The most significant example of this concerns the assessment of the extent to which single incidents of misconduct should be taken as indicative of the more general behaviour of practitioners.

In *Colagrande* (Notes Para 21) the Meeting found that the doctor's dishonesty 'was a single occurrence of serious professional misconduct. His case did not raise issues of his general competence or performance as a doctor.' The file indicates that early internal discussions between CHRE officers had raised concerns that such dishonesty could place patients at risk, and counsel for the GMC had put the same point to the Fitness to Practise Panel. It not clear how the evidence available to the S 29 Meeting could have justified an inference that the incident was an isolated one save by the absence of evidence of other dishonesty. However, the absence of such evidence could be as a result of the filtering out of material through earlier stages of the proceedings before the regulator. Where the GMC decides not to place evidence before the Fitness to Practise Panel it will not be accessible to CHRE. Possibly it would be more accurate to describe this as a situation where the S 29 meeting placed reliance on the finding to the FPP that the case was an isolated single case.

These problems became apparent from the case of *Bassiouny* (improper examination) where the meeting inferred that there must have been a sexual motive behind the touchings and that there were probably more incidents, although evidence only shows one. Later evidence that there was a series of similar allegations under consideration by GMC suggests case meeting was right and the High Court upheld the view that the GMC decision was unduly lenient (*CHRE v GMC* (2005) *Times* 7 February, [2005] EWHC 68 (Admin)). However, it is not clear whether this inference of other incidents

was really sustainable on evidence available at the time to the S 29 Meeting. It is interesting to note that the file shows that a second case meeting, held to consider whether or not the referral of the case to court should be continued (24 November 2005), concluded that it should not, but it became clear that the GMC wished the matter to be put before the court. One plausible explanation for this would be that it indicates concern on the part of the GMC that the procedural rules that prevent separate complaints being linked together might impair its ability to protect the public.

Sometimes, there were clear grounds on which an assessment could be made of whether a single incident was indicative of a wider problem. *Klentzeris* concerned research fraud. This was considered by the S 29 Meeting to be a one off and unlikely to lead to future misconduct. In this case there were specific facts from which it was possible to draw this conclusion. The doctor was not currently researching, and the mental health and stress that he was under at the time of the misconduct were no longer extant.

More commonly, however, it was difficult to assess and the evidence appeared to be open to different interpretations. *McCallam* was considered against a test based on the implicit seriousness of incident (Para 15). The matter was seen as a system failure that was outwith the doctor's control – he should have raised it with management but it was not a personal failure (Para 28). It seems to have been considered as an isolated incident, despite evidence of continuing weaknesses in the system (Para 29). It is difficult to see what evidence the S 29 Meeting had to assist it in determining whether there were grounds for wider concern. However, it seems to have disposed of the case by regarding it as within the scope of discretion of the regulator.

*Hora* (GMC) was seen as one incident in long career, giving rise to no public protection issue. However, it concerns the failure to examine properly as a Forensic Medical Examiner that could have indicated a lack of understanding of the responsibilities of an FME. This possibility does not seem to have been considered. This may be explained by the fact that the PCC had addressed case on basis that it was an isolated incident when it had been conceded by GMC counsel that there was 'no blemish' on H's record.

Most interesting on this point was *Simonet* (GCC) where one CHRE officer had taken the view that while the issues concerned a single patient, the failures were widespread and could be indicative of a significant problem. He suggested that the practitioner was inexperienced and there was a risk that he would continue to act in same way. The Director's report drew attention to these issues rather than indicating a recommended view. It is not clear from the record why not the case was not seen as indicative of systematic failure.

In contrast, in *Jellet* the S 29 Meeting felt unable to assume that there was no danger to patients and there was insufficient evidence available to allay their concerns.

### **General deterrence**

There was little evidence of discussion of the principles of deterrence in S 29 meetings. However, the concept of deterrence was frequently referred to, e.g. in *Jellet* (Notes Para 29) *Zaheer* (Notes Para 19) *Leeper* (Notes Para 20) *Southall* (Para 16), *Bee* (Notes Para 17), *Mitha* (Notes Conclusion Para b) and *Evans* (Notes Conclusion Para d). There may be some merit in the Scrutiny Committee considering the mechanics of deterrence in more detail, particularly as general deterrence seems to feature more highly in the thinking of the judiciary in the cases referred to them than it did in the S 29 Meetings.

Deterrence can take either a general or specific form. In the specific form, the deterrence is directed to the individual practitioner and serves as a disincentive for them to repeat their behaviour. General deterrence is directed against a wider group, demonstrating to them that they will suffer a sanction if they misbehave. General deterrence can only be effective if the application of sanctions is publicised and known to those who might contemplate misconduct of the type in question. This would perhaps be more effective if a single set of indicative sanctions were developed rather than relying on the different approaches being developed separately by the regulators. A publicised set of indicative sanctions might also reassure the public that regulators' views of the seriousness of certain types of offences are in accordance with more general public opinion.

## **Promoting Consistency**

In two areas there was evidence of interest at S 29 Meetings in consistency of CHRE decisions making.

- (a) Child pornography where CHRE officers have drawn up factors for consideration.
- (b) Pharmacists. In *Mitha* and *Evans* the meeting notes indicate that the panel noted that previous similar cases had not led to referral. Care was taken to make it explicit in the notes that this was not to be taken as precluding a referral in a similar case in the future. A pragmatic approach was taken of using the cases as an opportunity to initiate discussion with the RPSGB about procedures.

However, no formal discussion of the value of consistency over time – a form of doctrine of precedent - was identified. Such a doctrine would need to take into account variations between the powers of regulators but could be a useful guide in cases where the nature of the offence is the key issue. This is particularly important where the issue of public confidence in the regulatory systems is raised. Here, in part the Council needs to consider whether regulators properly reflect, without necessarily simply accepting, public expectations. It would not necessarily be appropriate for individual S 29 Meetings to discuss this policy issue, and it is under consideration by the full Council.

In relation to risk assessment, a common approach rather than a comparison of outcomes is more likely to give assurance of consistency as the variables are likely to

be greater. Consideration would need to be given to the identification of risks of harm to specific patients, or to categories of patients, or to the broader public (including harm through lack of confidence and trust in health professionals). This would include both the likelihood of risks manifesting themselves and also the seriousness of the harms if they materialised. Then an examination should be made of how those risks might be managed, including assessing the options available to the regulator. The decision whether or not to refer would then be made on the basis of the uncontrolled risks.

In relation to cases that turn on the nature of the misconduct, CHRE is developing tools to assess the seriousness of cases by examination of risk factors. There was insufficient evidence in the sample to draw conclusions on their use in practice, but they would seem broadly consistent with the past practice of S 29 Meetings. However, there is at this stage no clear guidance on how those tools would be used, and in particular whether they can be meaningful in the absence of some form of tariff. The tools will assist panels in considering whether this is a more or less serious example of the misconduct in question in respect of a number of dimensions. However, that would usually be used in sentencing practice to indicate that the normal penalty was too lenient (and therefore should be increased) or too harsh (and should be lowered). There may need to be some comparator, for which the expected sanction is established, to enable the most effective use of the risk criteria.

## Conclusions

In relation to the four questions anticipated when the research was commissioned, the conclusions are as follows

1. *Consistency of decision-making.* Only one area was identified in which there were concerns over consistency of outcome. In this area, one case involving an improper relationship between a female nurse and a patient, seemed to be dealt with more leniently than might have been expected. It was not possible to determine the cause of this, it may relate to issues of gender as well as profession, but it is recommended that it be considered carefully. Otherwise no significant differences were identified between regulators or within categories of misconduct.
2. *The typology used by CHRE staff to record different categories of cases.* A slightly different categorisation was used to analyse the cases in this sample than has been developed by CHRE staff. This was necessary to enable comparisons when the sample was so small. The picture would have looked different when all cases referred to CHRE, not merely those resulting in S 29 Meetings were considered. There was nothing to indicate that the internal CHRE categories were inappropriate for distinguishing between cases in this larger group but it was not possible to address this from the sample for this report.
3. *The advantages and disadvantages of CHRE adopting an across-the-board policy in relation to certain categories of cases.* It has been suggested that two broad tools to promote consistency could be considered. One deals with those cases



where the key concern is the management of identifiable risks to the public. The other deals with those cases where the most important factor is properly reflecting the nature of the misconduct.

4. *The extent to which consistent outcomes (as distinct from consistent processes) are necessary or desirable, together with suggestions for how such consistency might be achieved.* The Report suggests that consistency of process is the most helpful tool in cases where risk management is the most significant concern. In line with the work being progressed by CHRE it suggests that where the seriousness of the misconduct is the key concern, then a comparative approach to 'grade' misconduct is appropriate. However, it raises concerns that the benefits of a typology of 'risk factors' may not be fully realised without some indicative tariff.

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25 February 2005

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