Neutral Citation Number: [2018] EWHC 3157 (QB)

Case No: HQ18X01574

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 20/11/2018

Before :

MR JUSTICE JACOBS

- -

Between :

DR CAROLINE JANE ARDRON	**Claimant**
- and -	
SUSSEX PARTNERSHIP NHS FOUNDATION TRUST	**Defendant**

- -
- -

Jeremy Hyam QC (instructed by **RadcliffesLeBrasseur**) for the **Claimant**
Jeffery Jupp (instructed by **Brachers**) for the **Defendant**

Hearing dates: 5th, 6th and 7th November 2018

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Judgment Approved

Mr Justice Jacobs:

A: Introduction

1. The Claimant, Dr. Caroline Ardron ("Dr. Ardron"), is a very experienced consultant psychiatrist employed by the Defendant ("the Trust"). The Trust considers it appropriate for Dr. Ardron to face disciplinary proceedings for alleged gross misconduct relating to her work at HMP Lewes in late 2015 and early 2016. At that time, Dr. Ardron was the responsible clinician of a young prisoner known as JO, who committed suicide by hanging himself on 12 February 2016. The proposed disciplinary proceedings relate, almost exclusively, to Dr. Ardron's care of JO including her record-keeping in that respect.

2. Dr. Ardron does not suggest that disciplinary proceedings are inappropriate as a matter of principle, or that there is no case of misconduct that could be brought against her. However, she contends that there is no basis for a charge of gross misconduct; a charge which, if established, could potentially lead to the termination of her contract and serious ramifications for her including her prospects of obtaining subsequent employment. On 18 June 2018, an interlocutory injunction was granted by Mr. Pushpinder Saini QC, sitting as a Deputy Judge of the High Court, which restrained the Trust from proceeding until further order with a disciplinary hearing into gross misconduct.

3. The question for resolution now is whether that injunction should be made permanent. That issue depends upon whether Dr. Ardron can prove that the Trust will breach her contract of employment by holding the proposed disciplinary hearing on a charge of gross misconduct. The Trust's intention to proceed to such a hearing was communicated in its letter to Dr. Ardron dated 20 March 2018, and the issue is therefore whether the Trust should be prevented from operating on the basis of that letter. The resolution of that issue depends principally upon the question of whether the facts found in an investigation into Dr. Ardron's conduct could, taken at their highest, amount to gross misconduct.

4. Most of the trial was spent on submissions of counsel based on the documentary record, and in particular as to the findings in the very detailed 72 page report of Dr. Wijetunge. That investigation was carried out by consultant psychiatrist Dr. Aruna Wijetunge ("Dr. Wijetunge"). That report contained a very large number of appendices, to which reference was also made in the parties' submissions. Dr. Wijetunge had been appointed as "Case Investigator/ Investigating Officer" pursuant to the Trust's procedures for investigating allegations or concerns about a practitioner. These procedures, which were contained in the Trust's policy entitled "Managing Concerns about Medical Staff Policy" ("MCMSP"), implemented the requirements of Part I of "Maintaining High Professional Standards in the Modern NHS" ("MHPS") which came into effect in 2005.

5. Two witnesses gave evidence at trial: Dr. Ardron and, on behalf of the Trust, Dr. Duncan Angus. Both witnesses had previously made a number of witness statements. Dr. Angus was a consultant psychiatrist who, in addition to his clinical duties, was Deputy Medical Director of the Trust. Importantly, he was also (in accordance with MHPS) the "Case Manager" who was responsible for appointing Dr. Wijetunge as "Case Investigator". Dr. Angus was therefore responsible for the decision that Dr. Ardron should face a case of gross misconduct. He was also responsible for a document entitled "Management Statement of Case" dated 19 April 2018 ("MSC"), which set out the detail of the case which the Trust wished to advance against Dr. Ardron.

6. It is important to emphasise at the outset that the trial was not concerned with the question of whether or not Dr. Ardron was guilty of gross misconduct, still less whether dismissal was an appropriate sanction in the event that gross misconduct were to be established. Accordingly, nothing that is contained in this judgment should be regarded as giving any indication or steer to a disciplinary panel as to how those issues should be resolved. Rather, the essential issue is whether it is appropriate for the Trust to make that case against Dr. Ardron at all, and whether it is a breach of contract to do so. In answering that question, it is necessary to consider whether the facts found in Dr. Wijetunge's report and its Appendices can properly found a case of gross misconduct, and to that extent only it is necessary for me to express a view on the facts as they emerge from that report and appendices.

7. Since the trial was not concerned with an investigation of Dr. Ardron's conduct, neither her written nor oral evidence (which was relatively brief) was central to the issues to be resolved, and indeed it was not referred to in any detail during either counsel's closing argument.

8. The evidence of Dr. Angus was more pertinent to the issues at trial, and in particular the allegation by Dr. Ardron that Dr. Angus had failed to ask the right questions (i.e. he had 'misdirected' himself) when deciding whether or not there was a case of gross misconduct. I was left in no doubt that Dr. Angus had taken a very careful and conscientious approach to the question of whether Dr. Ardron should face that case, and that it was not a decision that he had made lightly. He had taken great care in the drafting of the original Terms of Reference which formed the basis of Dr. Wijetunge's remit. He had then spent a very considerable amount of time in reading and re-reading the report and appendices. I was also left in no doubt that he considered, rightly or wrongly, that there had been very serious misconduct by Dr. Ardron over a period of some months, with repeated failures in respect of different aspects of the care relating to JO. His genuine view was (again, rightly or wrongly) that what had occurred and went beyond a case of (as he put it in his second witness statement) an "isolated incident or a small number of incidents of negligence" which "would not have led to a case to answer for gross misconduct". I accept his evidence that this was his approach, and I address below the Claimant's submission that this was not reflected in the contemporaneous documents.

B: The Factual Background

B1: The contract between Dr. Ardron and the Trust

9. Dr. Ardron was a consultant psychiatrist employed full-time by the Trust since 2010. There was evidence before me that she has had an unblemished career and is and was highly regarded by her colleagues. In the autumn of 2015 she was employed for half of her time at HMP Lewes as resident psychiatrist, and she had an office there. That prison held both remand and short-sentenced prisoners. Her timetable involved her attending HMP Lewes on Wednesdays, when she would attend the Healthcare Wing at the prison, and Thursdays.

10. Dr Ardron's job description required her to work within a multi-disciplinary team at HMP Lewes to provide "high quality specialist assessment, treatment and care to prisoners within HMP Lewes …". Her contract was subject to the standard terms for NHS Consultants, and these required her to maintain professional standards and to keep proper records and reports incidental to their practice. It also incorporated the Trust's disciplinary policy and procedures. Clause 1.2 contained a definition of Gross Misconduct:

> Gross Misconduct
> Gross Misconduct is misconduct of such a nature that the Trust is justified in dismissing the member of staff who commits the offence. Such offences may warrant summary dismissal without any prior warnings. (See Appendix 3)

11. Appendix 3 repeated this definition, and then contained a list of behaviours/ actions which the Trust considered "as gross misconduct". This included matters such as assault, corruption, and fraud as well as:

- Breach of trust and confidence - conduct which amounts to a breach of the implied contractual term of trust and confidence.
- Negligence - any action or failure to act which could result in serious loss, damage or injury. Includes failure to give appropriate care and protection to service users.
- Wilful breaches of professional codes of conduct.

12. The identification of behaviours/ actions in Appendix 3 relating to "Gross Misconduct" was separate from a list of behaviours/ actions which were simply "Misconduct" and were listed in Appendix 2. Misconduct was defined in Appendix 2 as a "breach of the Trust's policies or rules and/or a failure to observe standards of expected conduct at work". The list included:

    - Any action detrimental to the care and treatment of service users (not constituting negligence – see Gross Misconduct)

B2: JO and Dr. Ardron's care

13. JO was a young prisoner, aged 19 at the time of his death in February 2016, at HMP Lewes. On 18 November 2015 he hanged himself in his cell. At that time, he was discovered and resuscitated by staff at the prison, and was then admitted to hospital and treated. This was obviously a very serious incident, and without the cardiopulmonary resuscitation performed by the prison staff, it was unlikely that JO would have survived. When he was returned to HMP Lewes he was a person with a high suicide risk.

14. Upon his return, he was placed at the Healthcare Wing of the prison. He remained there until the time of his death in February 2016. He was first seen by Dr. Ardron on 25 November 2015 during her ward round. Following her assessment, an entry was made on his clinical record by Dr. Ardron's secretary. On the following day, 26 November, Dr. Ardron completed a recommendation for JO to be transferred to a hospital under Section 48 of the Mental Health Act 1983 ("MHA"). Dr. Ardron noted in the Section 48 documentation that there was evidence of an underlying psychotic illness. Her formulation (i.e. working diagnosis) was schizophrenia. However, Dr. Ardron did not prescribe any medication for JO and therefore no treatment for the psychotic illness was given during the time that JO was awaiting transfer to a hospital.

15. Thereafter, it was Dr. Ardron's case and evidence that she saw JO on four occasions, but she was only able to carry out what was described as a "hatch" review. In other words, she was only able to see and communicate with JO by opening the "hatch" on the door to his cell. None of these hatch reviews was, however, documented in JO's clinical record – although, at least for the purposes of the issues at trial, the Trust did not dispute that these reviews had taken place.

16. During December 2015 and January and February 2016, JO was seen by a number of other psychiatrist including Dr. Tariq (who was Dr. Ardron's trainee), Dr. Daniel Hume (a consultant psychiatrist) and Dr. Richard Noon (Clinical Director for Forensic Healthcare at the Trust). There were also ongoing discussions between Dr. Ardron

and her colleagues concerning JO's transfer to hospital pursuant to her original recommendation. That transfer did not, however, take place.

17. On 12 February 2016, JO was found by staff on the floor of his cell with a ligature around his neck made from a torn sheet. Resuscitation attempts were unsuccessful.

18. A complaint was made by JO's family in May 2016. An investigation was then carried out by the Prison and Probation Ombudsman and a draft report was issued in August 2016. The draft report noted that there was no evidence that a resident psychiatrist had reviewed JO since 8 December 2015, and that JO's prison records were incomplete and did not provide clear evidence of the decisions about his assessment. The Ombudsman also recorded the views of Dr. Catherine Kinane, who had assisted him as the clinical reviewer. She concluded that the care that JO received at Lewes was not equivalent to that he could have expected in the community. In particular, his care plan had not been updated, there was no risk assessment or risk management plan, and he was not on medication. She commented that consistently documented examinations of his mental state would have identified a pattern of deterioration of his psychosis.

19. The Trust also carried out its own Serious Incident investigation. This identified a number of "Care and service delivery problems", including (but not limited to) matters which were within Dr. Ardron's sphere of responsibility. These included adverse comments concerning (i) the recording of clinical reviews and (ii) the fact that at "no time was medication prescribed therefore nursing staff did not have the opportunity to persuade him to accept treatment during periods when he may have been assessed as being potentially compliant".

20. The Trust's case was that there was evidence to suggest very serious deficiencies in Dr. Ardron's professional work in relation to JO. In summary:

    a) She had not undertaken a proper psychiatric assessment on 25 November 2015 when she first met JO. Her secretary had recorded the inadequate assessment that was undertaken. Her formulation of schizophrenia was not recorded in JO's clinical record.
    b) When she drafted the Section.48 MHA referral, she did not mention that JO had recently attempted suicide. She therefore did not include in the assessment information which was necessary to ensure that JO was transferred swiftly on the basis of the risk he posed to himself.
    c) Thereafter, Dr. Ardron made no notes of any interaction with JO. There was literally nothing written by Dr. Ardron for the next 2 ½ months.
    d) She failed to undertake or record any risk planning.
    e) She failed to document the hatch reviews she says she undertook.
    f) She failed to document the outcome of meetings with other professionals.
    g) She failed to prescribe medication.
    h) She failed to record her interactions with colleagues.

21. Dr. Ardron accepted these criticisms at least to some extent. However, it was submitted on her behalf that it was important to consider any criticisms in context. For example, although there may have been deficiencies in her record keeping, she was continually involved in referral meetings and by email seeking to facilitate JO's transfer to hospital, where it would have been possible to medicate him even if he

refused treatment. There were also real difficulties in communicating with JO: he was on "restricted unlock" which meant he could only be seen through his hatch, unless there were sufficient prison officers available to facilitate a meeting in a more conventional way. There were also difficulties in making computerised entries, because she had not been provided with a computer that was compatible with the prison healthcare system and that she could use when in the Healthcare Wing of HMP Lewes. JO had also expressed his unwillingness to take medication, and had sought to negotiate his way out of the Healthcare Wing on the basis that he would only take medication if that transfer was arranged.

B3: Dr. Wijetunge's investigation and report

22. An investigation was then undertaken in accordance with the Trust's procedures. Dr. Angus was appointed as Case Manager. On 20 October 2016, Dr. Ardron was advised that the Trust was undertaking a formal investigation into her conduct and capability following concerns that had arisen during the investigation and review into the death of JO whilst under her consultant care. She was advised that the concerns about her conduct, if found proven, could be considered gross misconduct. She was told that Dr. Angus was the Case Manager, and Dr. Wijetunge was the Case Investigator.

23. The legal background to Dr. Wijetunge's investigation is explained in the decision of the Supreme Court in *Chhabra v West London Mental Health NHS Trust* [2015] ICR 194 *("Chhabra")*. In summary, under procedures introduced in 2005, the Secretary of State for Health directed all statutorily defined "NHS" bodies in England and Wales to implement the full version of the framework contained in MHPS. This set out procedures for the initial handling of concerns about doctors and dentists. 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.

24. The case investigator's role was to give the manager sufficient information to enable him or her to decide whether, amongst other things, there was a case of misconduct which should be considered by a disciplinary panel: *Chhabra* para [6]. 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: see *Chhabra* para [17].

25. The respective roles of the case investigator and case manager are explained in paragraphs [30] – [32] of Chhabra, which are material to some of the arguments advanced in this case.

> [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 16–17 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.

26. There was no material difference between the policies implemented by the West London Mental Health Trust considered in *Chhabra* and the policy contained in the MCMSP implemented by the Trust. Thus, the MCMSP provided (section 3.1.13) 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". Section 3.1.17 provided that the investigator had

> … discretion on how the investigation is carried out but in all cases the purpose of the investigation is to ascertain the facts in an unbiased manner. Investigations are not intended simply to secure evidence against the practitioner as information gathered in the course of an investigation may clearly exonerate the practitioner or provide a sound basis for effective resolution of the matter.

Section 3.1.19 provided that

> The report of the investigation should give the case manager sufficient information to make a decision whether:
> - There is a case of misconduct that should be put to a conduct panel;

27. For the purposes of his investigation, Dr. Wijetunge was provided with detailed Terms of Reference ("TOR") which Dr. Angus had drafted. In doing so, Dr. Angus had the benefit of the draft Serious Incident and draft Ombudsman reports, and he was therefore able to be very specific about the areas to be considered, although there was a degree of overlap between some of the TOR's. These were as follows:

- TOR 1: To establish the facts with regards to Dr Ardron's attendance at Ward Reviews between 4 September 2015 and 10 March 2016.

- TOR 2: For ward reviews that did not take place between 4 September 2015 and 10 March 2016 to establish why that was the case and did Dr Ardron's conduct in this area meet professional standards of good practice.

- TOR 3: To establish when Dr Ardron completed her initial comprehensive mental health assessment of patient JO and where that assessment is recorded.

- TOR 4: When JO was returned to HMP Lewes on 20 November 2015, following his treatment on ITU, did Dr Ardron conduct the psychiatric assessment as advised and at the earliest opportunity? If not, to establish the reasons for that, and did her conduct in this area meet professional standards of good practice.

- TOR 5: To establish that any non-NHS commitments, independent or private work that Dr Ardron may have undertaken between 4 September 2015 and 10 March 2016 (specifically including, but not limited to, seeing prisoners at Lewes Prison as an independent doctor under the instruction of the Crown Prosecution Service, Solicitors or Courts for the purposes of preparing an independent medico-legal report) did not take place during NHS time. To establish, if relevant, that any independent work undertaken did not occur at the times of the Ward Reviews. To establish that Dr Ardron's conduct in this area met professional standards of good practice.

- TOR 6: To establish what was Dr Ardron's clinical formulation of JO and how, if at all, that evolved over time.

- TOR 7: To establish if Dr Ardron met professional standards with regards to her clinical formulation, investigations, risk assessment and risk management plan, treatment plan and plans for review.

- TOR 8: To establish if Dr Ardron's liaison, and direct communications with, other clinicians who had seen and assessed JO met professional standards of good practice.

- TOR 9: To establish how, if at all, Dr Ardron incorporated these other clinicians' findings into her on-going review of her clinical formulation, investigation, risk assessment and management plans, treatment plans and plans for review of JO.

- TOR 10: To establish that Dr Ardron's clinical and professional supervision of her trainee between 4 September 2015 and 10 March 2016 met professional standards of good practice.

- TOR 11: To establish that Dr Ardron's clinical and professional leadership met professional standards.

- TOR 12: To establish that Dr Ardron's working with governance structures met professional standards.

- TOR 13: In the event it is found Dr Ardron's practice breached professional standards of good practice to further comment on any breach established in the context of her practice being in a prison setting and in the context of the resources she had available to her.

28. Dr. Wijetunge's investigation took longer than anticipated for reasons which it is not necessary to explain (but which did not reflect on Dr. Wijetunge). His investigation was clearly very thorough, and the resulting report was detailed and the product of a very considerable amount of work. Although Dr. Wijetunge was himself a psychiatrist, he was assisted by an expert adviser. This was Dr. Janet Parrott, who was not an employee of the Trust. Dr. Wijentunges report was in due course submitted to Dr. Angus on 20 November 2017.

29. Dr. Wijetunge concluded that in a number of respects Dr. Ardron's conduct had not met professional standards of good practice. In broad summary these were as follows.

30. *(1) Inadequate documentation of the initial assessment.* Dr. Wijetunge concluded that whilst Dr. Ardron had carried out her initial assessment of JO at the earliest opportunity, the level of information documented in the clinical record of that assessment did not meet professional standards of good practice. In her interview with Dr. Wijetunge, Dr. Ardron agreed that the assessment was not adequate. Dr. Parrott's view was that the following matters should have been documented:

    a) Statements about JO's sleep, appetite, the presence of sustained mood disturbance and the presence of psychosis;
    b) A clear statement about the clinical formulation – this need not have been elaborate, but a succinct statement about formulation would be expected practice;

c) A treatment plan for JO – for example the need for regular or further review, and whether medication would have been helpful or not.

31. Dr. Ardron's clinical formulation of JO was that he was suffering from an underlying psychotic illness. This was not, however, recorded in the clinical record – despite the fact that it was included in the Section 48 MHA recommendation. There were also alleged deficiencies in the MHA referral in particular the failure to refer to the ongoing suicide risk.

32. *(2) Failure to check records.* The entry in JO's clinical record relating to the initial assessment had been written up by Dr. Ardron's secretary. Dr. Ardron would be expected to check the entries and take steps to address any omissions or errors, since it would not be reasonable to expect a secretary to be able to identify what was the clinically relevant information. The relevant entry, if made by an administrative member of staff such as Dr. Ardron's secretary, should have been countersigned by a qualified member of staff. There was no evidence that this had been done.

33. *(3) Failure to plan care.* Although there was a plan to move JO to a hospital, there was no other management or treatment plan documented in the clinical entry resulting from Dr. Ardron's 25 November 2015 assessment (apart from obtaining GP records and consulting with his offender manager). Nor was there any documentation about Dr. Ardron's plans further to review JO.

34. *(4) Failure to prescribe medication.* Although Dr. Ardron was of the opinion that JO had a psychotic illness, she made no plans for the prescribing of medication. Dr. Ardron accepted during the investigation that, on reflection, she should have prescribed medication, which could have been offered to JO by nursing staff during periods when he was more able to engage with them.

35. Paragraph 10.108 of Dr. Wijetunge's report encapsulates the (1) – (4) in the following terms:

> 10.108 Based on the evidence set out above and the standards considered:
>
> - From her statement and interview for this investigation, Dr Ardron has provided a clinical formulation for JO. This though is not documented in JO's clinical record; as such, she did not meet the professional standards set out in "Good Medical Practice" and "Good Psychiatric Practice" for her formulation.
> - From her interview for this investigation, Dr Ardron has outlined what investigations she considered appropriate for JO and why it was not possible to provide this in the Healthcare Wing. This level of detail though is not documented in JO's clinical record; as such, she did not meet the professional standards set out in "Good Medical Practice" and "Good Psychiatric Practice" for the investigations for JO.
> - From her statement and interview for this investigation, Dr Ardron has provided a description of the risks that JO was posing to himself and to others. There is only a limited documentation of this though in Dr Ardron's entries in JO's clinical record (focused around his suicidal ideas). Although the available policies do not stipulate that Dr Ardron would

have been required to document formal risk assessments herself, "Good Psychiatric Practice" does state that psychiatrists must be competent in assessing and documenting risk. Apart from completing the Section 48 of Mental Health Act 1983 recommendation for hospital transfer, there is no documentation in the clinical record of any other aspects to Dr Ardron's risk management plan for JO. As such, she did not meet the professional standards set out in "Good Medical Practice" and "Good Psychiatric Practice" for risk assessment or risk management for JO.

- From her statement and interview for this investigation, Dr Ardron has said that JO needed hospital transfer for treatment of his underlying psychotic illness. She said that she offered JO medication when she saw him for hatch reviews between 25 November 2015 and 12 February 2016 but he declined this - there is no documentation of these reviews. Although she thought JO had a psychotic illness, she did not prescribe any medication that nursing staff could offer to him if he had a more compliant period. Based on what is set out in "Good Medical Practice" and "Good Psychiatric Practice" and on the opinion of the expert advisor, Dr Parrott, Dr Ardron did not meet professional standards in terms of her treatment plan for JO.
- Although Dr Ardron felt that JO needed transfer to a hospital due to his underlying psychotic illness, there is no documentation of what her plans for review of him were whilst he was on the Healthcare Wing in the clinical record. From her statement and interview, over the course of JO's period of care on the Healthcare Wing (12 weeks), she saw him on 5 occasions (once in Ward Review and on four occasions on hatch reviews). There is no explicit statement in the available policies about how often a patient on the Healthcare Wing should be seen (although the expert advisor, Dr Parrott, said that regular reviews of mental state would be appropriate for someone awaiting hospital transfer). None of the reviews that Dr Ardron said she had carried out after 25 November 2015 are documented though; for this reason, site did not meet standards set out in "Good Medical Practice" and "Good Psychiatric Practice" in regard to her plans for review of JO.
- In conclusion, based on the available evidence, Dr Ardron did not meet professional standards set out in "Good Medical Practice" and "Good Psychiatric Practice" with regards to her clinical formulation, investigations, risk assessment and risk management plan, treatment plan and plans for review for JO.

36. *(5) Failure to keep adequate records of JO.* Although Dr. Ardron said that she had assessed JO through the hatch of his cell on approximately four occasions, there were no documented records of this. Dr. Ardron accepted in her evidence before me that apart from the assessment recorded by her secretary in respect of the initial assessment on 25 November 2015, there was no other note in JO's medical notes from, or attributed to, Dr. Ardron from that date until JO's death.

37. *(6) Failure to document discussions in meetings and referral outcomes.* There was a failure to document discussions which took place in various relevant meetings, namely referral meetings and meetings with other clinicians. There was also a failure to document how Dr. Ardron had incorporated the views of other clinicians into her

clinical formulation, investigation, risk assessment, and management and treatment plans.

38. When addressing TOR 12, Dr. Wijetunge said:

> 10.158 General Medical Council document, "Good Medical Practice". Dr Ardron did not meet standards for this governance structure in the following areas: documentation of her initial assessment of JO (see 10.68 above); documentation of her clinical formulation of JO (see 10.108 above); documentation of what investigations she considered appropriate for JO (see 10.108 above); documentation of her risk assessment and risk management plan for JO (see 10.108 above); not prescribing appropriate medication for the psychosis she believed JO was suffering from for nursing staff to offer (see 10.108 above); not documenting the hatch reviews she said were completed after her initial assessment of JO (see 10.108 above); not documenting the discussions she had with other professionals about JO and the outcome of these discussions (see 10.121 above).

39. The matters set out above were referable specifically to JO. However, TOR 1 and 2 were more general and concerned Dr. Ardron's attendance at Ward Reviews. This is described in detail in section E3 below.

40. Dr. Wijetunge's report also said that the available evidence indicated that there were "points of context in regard to the prison setting and resources available to Dr Ardron that should be considered when looking at the areas where she did not meet professional standards of good practice". These include the reduction in consultant psychiatrist time allocated to HMP Lewes; the high proportion of patients awaiting transfer to hospital from the Healthcare Wing when JO was a patient there; the problems with the computer systems in the Healthcare Wing, which meant that Dr. Ardron could not input clinical entries; and deficiencies in the care provided by other members of staff at HMP Lewes.

B4: Events subsequent to Dr. Wijetunge's report

41. Dr. Wijetunge's report was considered by Dr. Angus and two colleagues at a decision making meeting on 8 January 2018. This meeting lasted approximately 3 hours, and "draft notes" of that meeting (6 pages) were subsequently made. A further such meeting took place on 8 February.

42. On 27 February 2018, Dr. Ardron was notified by letter that she was required to attend a formal disciplinary hearing. The letter identified that the conduct which was alleged not to have met professional standards of good practice. It did not specifically refer to "gross misconduct". It is, however, clear from the internal e-mail correspondence 22 February 2018 between Dr. Angus and his colleague Jo Russell that this was the allegation that would be made, and that this would be communicated in a subsequent letter. (Indeed, Dr. Ardron had been advised back in October 2016 that that if the Trust's concerns about her conduct were found proven, that may be considered to be gross misconduct). On 20 March 2018, she was informed by the Chief Operating Officer of the Trust that the hearing would take place on 10 April

2018. As contemplated in the 27 February email correspondence, that letter did refer to gross misconduct. It provided in material part as follows:

> Dear Dr Ardron
>
> **NOTIFICATION OF DISCIPLINARY HEARING – TUESDAY 10 APRIL 2018**
>
> I am writing following Dr Angus' letter dated 27 February 2018 confirming his decision that you will be required to attend a formal disciplinary hearing.
>
> As outlined in his letter, on the basis of the investigation report received, Dr Angus decided that you will be required to attend a formal disciplinary hearing to consider the allegation your conduct did not meet professional standards of good practice in the following areas:
> - attendance at ward rounds
> - clinical assessments, formulation, and treatment planning
> - on-going assessment and ongoing management of risk
> - ongoing clinical reviews of the patient
> - record keeping
> - provision of clinical and professional leadership
>
> At this hearing these allegations will be discussed and you will have the opportunity to put forward your case.
> In accordance with the Trust disciplinary policy, these allegations could constitute:
> - Negligence
> - Wilful breach of professional code of conduct
> - Breach of Trust and Confidence
>
> which are considered gross misconduct within the Trust's Disciplinary Policy and Procedure. Therefore one outcome of the hearing could be your dismissal from the Trust.
>
> Dr Angus has advised that whilst allegations regarding your capability were investigated, he has decided that there are no concerns regarding your capability and therefore this will not to be considered as part of this hearing.
>
> The disciplinary hearing will commence at **9.30am on Tuesday 10 April 2018 in Aldrington House, 35 New Church Road, Hove East Sussex BN3 4AG in the 2nd floor meeting room.** The HR meeting room will be available for you and your representative from 8.30am should you require this.

43. On 29 March 2018 and 4 April 2018, Dr. Ardron's solicitors sent two pre-action letters to the Trust. Dr. Ardron's case in those letters, as indeed it was at the trial, was that the Trust had wrongly categorised the case against her as "gross" misconduct. By way of response, the Trust's solicitors confirmed that they would be providing Dr. Ardron with additional information in the form of a Management Statement of Case, and that this would provide further clarification of their approach. The MSC was served on 19 April 2018.

44. The MSC is an 18 page document, prepared by Dr. Angus, which set out the Trust's case in relation to Dr. Ardron's alleged misconduct. Having set out the background to the investigation, Dr Angus described his review of Dr. Wijetunge's report. He said:

> I remain concerned about Dr Ardron's conduct and I am of the opinion there is no reasonable alternative other than going to a hearing so that the remaining issues of concern may be formally considered in accordance with the Policy.
>
> Based on the content of the evidence obtained, Including the Case Investigator's report and the witness statements of Dr Caroline Ardron, Dr Richard Noon and Dylan Wright I consider it is reasonable to conclude that Dr Ardron is a capable clinician. There is evidence she has the Consultant level skills and ability to assess, formulate, treatment plan, review and manage patients under her care.
>
> It is suggested by the Case Investigator's report and appendices that Dr Ardron has a good understanding of her professional and clinical roles and responsibilities.
>
> Having carefully considered the evidence, as Case Manager, I consider there remain concerns about the gaps laid open in the Case Investigator's report with regards to the weekly ward rounds and content of the clinical record. There does not appear to be a reasonable explanation for this and the investigation report sets out the areas where it is considered Dr Ardron's conduct fell below the professional standards required of her.
>
> The investigation report and appendices have not set aside concerns with regards to the number of patients Dr Ardron saw on a weekly basis in the context of ward rounds.
>
> Dr Ardron's apparent failure to keep adequate medical records is not adequately explained within the Case Investigator report and appendices. It is accepted the Case Investigator's report has highlighted some difficulties, including accessing relevant electronic systems, amending and updating records and the ability to access a relevant template document. However, it is apparent Dr Ardron could and should have kept suitable records. She had an office with access to the electronic healthcare records and other than the points referenced above and in the Investigation Report she has failed to provide an adequate explanation concerning her failure to meet the required standard for record keeping.
>
> It is clear Dr Ardron pursued the transfer of Mr JO from Prison to a hospital setting, however I concur with Dr Janet Parrott (independent expert advisor supporting the case investigator) that the anticipated transfer to hospital does not explain why Dr Ardron wasn't reviewing Mr JO on a regular and frequent basis as evidenced by entries in the clinical record.
>
> Dr Ardron did not prescribe treatment for Mr JO's psychosis. I find this concerning, and have taken into consideration her explanation of why not, and the views of Dr Janet Parrott (external expert advisor supporting the case

> investigator). I note in the witness statement from Dylan Wright he said in response to a question about whether it was discussed to offer Mr JO medication to that he could take them voluntarily *"this* was *documented when he* was *seen for the first time. Nurses would try and engage with JO and there were times when he was fairly good"* (page 4, para 5 of DW's statement). I understand the view is that Mr JO might be calmer on occasions and could have been persuaded to take treatment, had it been prescribed, during such periods.
>
> I concur fully with the view of Dr Catherine Kinane that the failure by Dr Ardron to consistently document her clinical examination of Mr JO's mental state meant the deterioration of his psychosis was not identified during the time he was under her consultant care.
>
> Neither the Case Investigator's report nor the appendices set aside my concern that Dr Ardron's section 48 documented clinical assessment made no reference to his ongoing high suicide risk or his recent treatment on ITU following a serious attempt to hang himself.
>
> With regards to Dr Ardron's clinical formulation I agree, and place weight on, Dr Parrott's comments with regards to the inadequacy of the documented assessment. It is clear Dr Ardron's clinical understanding at the time was fuller: as recorded in the section 48 papers.

45. The MSC then went on to discuss each of the TORs which had been considered by Dr. Wijetunge, identifying those where the Trust alleged that Dr. Ardron's conduct was alleged to fall short of the required standards, as well as those (such as her professional supervision of her trainee) where the evidence showed that Dr. Ardron had met professional standards. The conclusion of the report was in similar terms to the letter of 20 March 2018, namely that there was a case to answer at a disciplinary hearing in relation to the following concerns:

- attendance at ward rounds
- clinical assessments, formulation, and treatment planning
- on-going assessment and ongoing management of risk
- ongoing clinical reviews of the patient
- record keeping
- provision of clinical and professional leadership

46. The MSC also reiterated that the Trust's case was that there had been gross misconduct. However, it was also made it clear that the matters to be pursued related to Dr. Ardron's conduct. She was a capable clinician, and there were no remaining concerns as to her capability.

47. In due course, she commenced the present proceedings and in June 2018 obtained an interim injunction as described above. In granting the injunction (see [2018] EWHC 1535 (6B)), the deputy judge emphasised on a number of occasions that he was only at that stage concerned with whether there was a serious issue to be tried in relation to

Dr. Ardron's allegations of breach of contract by the Trust. He was not determining whether there was in fact a breach of contract, which was a matter which could only be determined at trial.

C: The submissions of the parties

Dr. Ardron's submissions

48. The submissions of Mr. Hyam QC on behalf of Dr. Ardron were wide-ranging, but the essential points were as follows.

49. He submitted that the findings of fact and the evidence which Dr. Wijetunge records are not capable, taken at their highest, of supporting a charge of gross misconduct as that term is properly to be understood and construed in the employment context. Gross misconduct required either gross negligence or wilful default, and the matters complained of did not meet that threshold. Although there were some performance failings, these had to be judged in the context of very difficult working circumstances. Mr. Hyam also emphasised in his closing argument that any failings had to be seen in the context of the various matters including the positive work that Dr. Ardron did carry out, including: her continued liaison with the nursing and other staff and other colleagues; her attempts to have JO transferred to hospital; that other psychiatrists saw JO and did not prescribe medication; that JO was refusing medication, and that there are dangers in trying to push medication onto a resistant patient. When judged in the light of those circumstances, there was clearly no case of gross misconduct which could properly be advanced. Fairly read, the case was one of misconduct, not gross misconduct. In that context, and in particular in considering whether or not there was a repudiatory breach, it was also relevant to bear in mind Dr. Ardron's unblemished career

50. Mr Hyam relied upon the absence of any reference in the minutes of the meeting of the decision-makers in January and February 2018 to either gross negligence or wilful default. It was submitted that it was clear from those meetings, and from the MSC, that Dr. Angus had asked himself whether there was negligence, since this was the standard identified in Appendix 3 to the Trust's disciplinary policy contained in the MCMSP. But this was not a sufficient standard for gross misconduct, which was to be equated with conduct which repudiated the contract of employment. Although Dr. Angus had subsequently sought to explain that his decision-making process was referable to the seriousness of the misconduct, and the sheer number and repetitive nature of the failings, this is not reflected in the decision-making minutes or in the MSC. On the contemporaneous documentation, it appeared that Dr. Angus had never asked the question whether the charges constituted such serious misconduct as to be summarily dismissable; i.e. whether it reached the highest level of misconduct available, and the most serious sanction.

51. Mr. Hyam also relied upon the fact that neither Dr. Wijetunge nor the expert adviser, Dr. Parrot, had characterised Dr. Ardron's conduct as being grossly negligent, or gross misconduct, still less wilful default.

52. Mr. Hyam made various points relating to the witness statements served by Dr. Angus. He submitted that Dr. Angus had carried out his own internal investigation, and had based his conclusions on matters other than those covered by Dr. Wijetunge's

report. For example, Dr. Angus had looked at JO's medical records and concluded that JO was willing to receive and take medication, although that was not a conclusion reached by Dr. Wijetunge and was not put to Dr. Ardron as part of the investigation. He submitted that, generally, Dr. Angus had raised a series of points not arising from Dr. Wijetunge's report, but from his own personal investigation of matters which had never been put to Dr. Ardron.

53. A particular criticism was the case made in relation to Dr. Ardron's alleged failure to carry out ward rounds. On that issue, Dr. Wijetunge had concluded that there was a lack of evidence as to whether there had been a failure to comply with professional standards. Dr. Angus had failed to appreciate the crucial difference between a positive finding that no ward rounds had been carried out, and a finding that there was a lack of evidence.

54. Mr. Hyam made detailed submissions in relation to each of the specific TORs considered by Dr. Wijetunge. He drew attention to the way in which each TOR had been discussed in the January and February decision meetings, and how the case was ultimately advanced in the MSC. His submission was that, taken individually, none of the matters identified in relation to each TOR amounted to a case of gross misconduct. A theme in his submissions was that the focus of the Trust's case was Dr. Ardron's record-keeping. Whilst he acknowledged that there were some "regrettable" departures from good practice in that regard, criticisms of record-keeping could not properly form the subject of a gross misconduct charge. Moreover, there was nothing in the report of Dr. Wijetunge which could possibly justify an allegation that there had been a wilful flouting by Dr. Ardron of the terms of her contract.

55. At one stage in his argument, Mr. Hyam was inclined to accept that it was possible to consider Dr. Ardron's conduct and alleged failings as a whole; i.e. to consider their cumulative impact. In his closing submission, however, he submitted (relying upon *Schodlok v The General Medical Council* [2015] EWCA Civ 769) that this was not permissible; at least in so far as concerns a case based on gross negligence.

56. In addition to these fundamental arguments as to why the Trust had breached its contract by pursuing a gross misconduct case, Mr Hyam contended that the Trust was seeking to put before the panel complaints which had not been considered by Dr. Wijetunge and complaints in respect of which he had gathered no evidence. To some extent these arguments repeated those already set out above: in particular, the lack of evidence to support any finding of a wilful breach of professional standards, or a breach of the duty of trust and confidence, or gross negligence. Separately, reliance was placed on three specific matters in the MSC:

    a) Page 8 of the MSC stated: "the investigation report and appendices have not set aside concerns with regard to the number of patients Dr Ardron saw on a weekly basis in the context of ward rounds". It was submitted that this was not and had never been an issue investigated under the terms of reference.
    b) Page 10 of the MSC stated that "ward reviews did not occur although Dr Ardron was in the prison". It was submitted that this was not a finding in the report. Rather Dr Wijetunge's report concluded that there was a lack of documentation in the clinical record to sufficiently evidence that the reviews did occur on the dates scheduled for them.

c) Page 16 of the MSC purported to assess (without any evidential basis for so doing) the demands of patients awaiting transfer as requiring less intensive review: "such patients are clinically understood and, whilst they await transfer, this reduces the turnover of patients on the ward". It was submitted that this assessment finds no support or evidence in Dr. Wijetunge's report.

57. Finally, reliance was placed upon the fact that the Trust has permitted her to carry on working since May 2018. This demonstrated that there could have been no breakdown in the trust and confidence between her and the Trust, and reinforced the submission that Dr. Ardrons conduct could not amounted to gross misconduct.

The Trust's submissions

58. Mr. Jupp for the Trust submitted that the case manager's role was to determine whether there was a case to answer for misconduct and whether the matters are sufficiently serious to amount to gross misconduct. Here, there was ample evidence of a case to answer for gross negligence, ample evidence from which it could be inferred by the conduct panel that C's conduct was a wilful (i.e. a deliberate) breach of professional codes; and a clear evidential basis for a breach of the implied term of trust and confidence. The various failings were very serious. Despite Dr. Ardron's unblemished record and potential mitigation, there was a compelling prima facie case of gross misconduct.

59. As far as gross negligence was concerned, Dr. Ardron's failures encompassed her initial assessment of JO; her failure to either undertake ward rounds or to document them; her failure to have in place any management plan or plan for prescribing medication; her failure to document outcomes of referral meetings or of contacts with other clinicians. These failings plainly could result in serious loss, damage or injury. All amount to failing to give appropriate care and protection to service users and are within the definition of negligence in the Trust's disciplinary procedures. They occurred over a 10-week period when Dr. Ardron was in charge of caring for a very vulnerable prisoner who subsequently took his own life.

60. It was unsurprising that by way of example, in the Prison and Probation Ombudsman's initial report, the expert instructed (Dr. Kinane) had commented "that consistently documented examinations of [JO's] mental state would have identified a pattern of deterioration in his psychosis". The failure to document and treat C's condition was a serious failing and raises a case to answer for gross misconduct.

61. There was also a case to answer for wilful breach of professional codes. Mr. Jupp submitted that it would be open to the conduct panel to infer from the repeated failures of Dr. Ardron that her conduct was deliberate and that there was a wilful non-compliance with her professional codes. These were not isolated or low-level failures or shortcomings. They were repeated and to a significant degree inexplicable.

62. In relation to breach of trust and confidence, the Trust submitted that it was important not to overstate what was required to establish a breach of the implied term. The conduct does not actually have to destroy the relationship of trust and confidence. What is required is that Dr. Ardron would not, without reasonable and proper cause, act in a manner calculated or likely to destroy or seriously damage the relationship of trust and confidence: see *Mahmud v Bank of Credit and Commerce International SA* [1998] AC 20, 45-46. There can be no question that a conduct panel could conclude that Dr. Ardron's conduct was such that if it had not destroyed the relationship of trust and confidence it was likely to seriously damage it. Her failures, if proved, were likely to have that effect.

63. Essentially, a consultant psychiatrist, over a 10-week period failed to undertake significant aspects of her job. Whilst it is impossible to say that that her failings led to the death of JO (and no such allegation was made), it was likely to have increased the risk of serious harm to JO and/or expose the Trust to serious criticism.

64. The Trust submitted that the argument that Dr. Angus had 'misdirected himself' as to the relevant test was without foundation. Whilst the notes of the decision meetings in January and February 2018, and the MSC, do not use the expression "gross negligence", it was clearly the case that Dr. Angus applied his mind to the question of whether the matters alleged were sufficiently serious to raise a case to answer for gross misconduct.

65. The Trust contended that Dr. Angus had not raised matters that were not investigated by the case investigator, and they responded in detail to the three specific points which had been raised in that context.

66. As far as concerns mitigation, it was clear from the MSC that Dr. Angus had considered the mitigation, and that this had played some part in his decision as to whether to proceed to a formal hearing. However, this was not a case where mitigation provided a clear answer to the case of gross misconduct, and the relevant facts relating to the mitigation relied upon, and their significance in the context of Dr. Ardron's alleged failings, were matters for the disciplinary panel to consider.

67. Accordingly, whilst there were no doubt points that Dr. Ardron could raise, and that would be taken into account in determining whether or not she had indeed committed gross misconduct, and what the appropriate sanction would be, there was ample evidence to advance a case of gross misconduct to the panel.

68. The fact that Dr. Ardron has continued to be employed and not excluded under the MHPS was not a matter which can be used to suggest that the Trust did not regard this as a matter of gross misconduct. Dr. Ardron – although an experienced consultant – is now working under very close supervision. This does not suggest that the Trust has complete confidence in her. Furthermore, the circumstances in which a doctor can be excluded are heavily circumscribed by MHPS Part II and must only be done when necessary. Restrictions on practice are required to be considered first.

D: The relevant legal principles

69. There was no substantial disagreement as to most of the relevant legal principles. They can in my judgment be summarised as follows.

70. (1) The role of the case investigator (Dr. Wijetunge) is to investigate in order to discover if there is a prima facie case of misconduct. He cannot, however, resolve disputed issues of fact. The role of case manager (Dr. Angus) is to assess the evidence and decide whether there is a case which it is appropriate to send to a disciplinary panel. That includes deciding whether the matters are sufficiently serious so as to amount to a case, if proven, of gross misconduct: see *Chhabra* paragraphs [30] – [33].

71. (2) In making his decision on that issue, the case manager is entitled to consider the evidence and decide whether it is appropriate to characterise the relevant conduct as "gross" or "wilful", even if those expressions have not been used by the case investigator: see the decision of the Court of Appeal in *Chhabra* [2013] EWCA Civ 11, para [74] (reversed on other grounds).

72. (3) If (as here) it is alleged that it is a breach of contract by the Trust to pursue a case of gross misconduct before a disciplinary panel, then the question for the Court is whether the findings of fact and evidence, as found by the case investigator, when taken at their highest, are capable of supporting a charge of gross misconduct: *Chhabra* para [35].

73. (4) The question of whether the findings of fact and evidence are capable of supporting a charge of gross misconduct is an issue of law for the Court: see *Skidmore v Dartford and Gravesham NHS Trust* [2003] UKHL 721, paragraph [15] – [17]. Accordingly, the issue is not to be determined by the application of public law principles; e.g. by asking whether the case manager's decision took into account all relevant considerations, or was such that no reasonable case manager could have made. However, in an area involving technical matters which are outside the Court's ordinary expertise, the court should have proper respect for the views expressed by experts including, in the present case, Dr. Wijetunge, Dr. Parrott and Dr. Angus himself.

74. (5) The existence of mitigating factors upon which the doctor may be able to rely at a disciplinary hearing does not necessarily defeat the decision to hold a disciplinary hearing. The fact that mitigation may be available does not mean that a decision to refer a serious allegation to a disciplinary panel is in breach of contract or unlawful: see the decision of the Court of Appeal in *Chhabra* at paragraph [76].

75. (6) Where there are relevant and substantial issues of fact which require resolution, the panel is the appropriate body to resolve those issues: see the Court of Appeal in *Chhabra* at [72].

76. (7) The Court is discouraged from micro-managing the disciplinary process: *Kulkarni v Milton Keynes Hospital NHS Trust* [2009] EWCA Civ. 789. The Court is not required to intervene to remedy minor irregularities in the course of disciplinary proceedings: *Chhabra* para [39].

77. (8) The case manager cannot send to a conduct panel complaints which have not been considered by the case investigator or for which the case investigator has gathered no evidence: *Chhabra* para [32]. In that context, it was common ground that it was permissible for the case manager to consider both the report of Dr. Wijetunge, and the extensive Appendices (30 of them, numbered A – DD) annexed to the report. I also consider it permissible for Dr. Angus in the present case to look at JO's medical

records. These were referred to in Dr. Wijetunge's report, but they were not attached as Appendices. Dr. Angus's evidence (which I accept) was that medical records are not usually annexed to such reports, because of confidentiality concerns.

78. (9) The concept of "gross misconduct" in the employment law context connotes misconduct which justifies summary dismissal, and which therefore amounts to a repudiatory breach of contract. There is no fixed rule of law defining the degree of misconduct which will justify dismissal. Gross misconduct may include, but is not limited to, dishonesty or intentional wrongdoing, for example: conduct which is seriously inconsistent with the employee's duties to his employer; or conduct which is of such a grave and weighty character as to amount to a breach of the confidential relationship between employer and employee, such as would render the employee unfit for continuance in the employer's employment, and give the employer the right to discharge him. The focus is on the damage to the relationship between the parties. Dishonesty and other deliberate actions which poison the relationship will obviously fall into the gross misconduct category, but so in an appropriate case can an act of gross negligence. See *Adesokan v Sainsbury's Supermarkets Ltd.* [2017] EWCA Civ 22 paras [21] – [23] (Elias LJ). Very considerable negligence, historically summarised as "gross negligence" is therefore required for a finding of gross misconduct: *Sandwell & West Birmingham Hospitals NHS Trust* UKEAT/0032/09 at [112] – [113].

79. (10) If a contract defines misconduct to include a minor transgression, then this cannot override the law; viz that gross misconduct must involve a repudiatory breach of contract. Accordingly, the Trust accepted that in so far as Appendix 3 of its disciplinary procedure provided for the possibility of dismissal for negligence falling short of "gross" negligence, it had to be read as subject to the gloss that gross negligence – or at least serious negligence (see *Adesokan* at paragraph [29])– was required.

E: Analysis and conclusions

E1: Gross negligence

80. I start with the question of whether the findings of fact and evidence as found by Dr. Wijetunge, when taken at their highest, are capable of supporting a charge of gross negligence, an expression which I equate with very considerable negligence. At this stage I leave aside the argument that Dr. Angus misdirected himself and applied a lower test of "ordinary" negligence. Having read and re-read Dr. Wijetunge's report a number of times, I am left in no doubt that there is a case of gross negligence which it is appropriate for a disciplinary panel to consider, and that this is so notwithstanding possible arguments that Dr. Ardron may be able to deploy including mitigating factors and context. I shall use the expression "sufficient case" to describe my conclusion that the Trust's case passes the requisite threshold to enable a case properly to be brought before a panel, whilst I again emphasise that it is ultimately for the panel to determine whether that case is proven to be well-founded.

81. I agree with the Trust that the facts disclose a sufficient case that there were failings over a period of 12 weeks in relation to a vulnerable young man who had previously attempted suicide. These failings occurred in a number of different areas, as summarised in paragraph [20] and [30] – [38] above. An important failing, which Dr.

Ardron at least to some extent acknowledged, was her failure to prescribe medication for JO, in circumstances where her formulation was that he was suffering from a psychotic illness. Dr. Angus made the simple point in his oral evidence, and this is borne out by Dr. Wijetunge's report, that if someone has a psychosis, then he should be treated.

82. It is in my view wrong to see these various alleged failings as being unrelated to one another. They were in my view inter-related and it is appropriate to look at them cumulatively when considering whether the Trust has a sufficient case. For example, the failure to prescribe medication is related to other alleged failings, including the absence of any management or treatment plan documented by Dr. Ardron in JO's clinical records. Equally, the absence of proper record-keeping also seems to me to be related to the failure to provide treatment. This is illustrated by the point made by Dr. Catherine Kinane, namely that consistently documented examination of JO's mental state would have identified a pattern of deterioration of his psychosis. Had this deterioration been recorded, it seems possible that this could have led to other steps being taken, such as the provision of treatment.

83. I do not accept Mr. Hyam's argument that the focus of the Trust's case was on the absence of appropriate record-keeping. There are important aspects of the Trust's case which are not simply, complaints about record-keeping. The failure to provide treatment is an obvious and important example. The apparent absence of a risk management or treatment plan is another.

84. But in any event, the evidence to my mind indicates that, certainly in the present context, proper record-keeping is of considerable importance. Appropriate records have potentially an impact on patient care. As Mr. Jupp submitted, the clinical records should give an accurate account of the ongoing story to anyone looking at them. For example, the doctor with responsibility for the patient can look at the records and can be reminded of his history. It can also see any deterioration in the patient and review or adjust plans accordingly. Other doctors can also see the clinical records, and this may inform their decision-making or advice. The records are also important as a protection for the treating doctor and his or her employer; in particular if questions are subsequently raised by the patient's family, or if negligence proceedings are brought, or if there is an inquest, or if (as happened in the present case) there is a potential loss of the Trust's contract with the prison. It is therefore not surprising that the professional standards recorded in Dr. Wijetunge's report refer to the importance of clinical records. For example, "Good Psychiatric Practice" states that "a psychiatrist must maintain a high standard of record keeping" and that "electronic records must be detailed, accurate and verified".

85. For these reasons, I therefore do not agree with the proposition that the present case does not meet the requisite threshold because it is just a case about record-keeping.

86. Mr. Hyam suggested, in his closing argument, that it was inappropriate to look at the various failings on a cumulative basis for the purpose of deciding whether there was a sufficient case of gross negligence. He submitted that each failing had to be looked at individually, and a decision made as to whether or not that failing – if it had stood alone – would justify a gross negligence case. I do not agree with that approach. This case is concerned with different aspects of the care provided to JO over a period of 12 weeks and Dr. Ardron's conduct in that regard. Furthermore, as I have said, the

various failings are interrelated. In those circumstances, it is appropriate to look at the failings as a whole. Indeed any other approach is in my view artificial. It would result in each failing being looked at on the basis that nothing else was to be criticised, in circumstances where factually that was not the case. I could well understand that would be no gross misconduct case if the only relevant failing had been, for example, a failure properly to document the initial assessment, but that every other aspect of JO's treatment over the next 12 weeks had been in accordance with professional standards. But on the basis of Dr. Wijetunge's report, this was not the case. And the Trust's case was that the inadequacies in the recording of the initial assessment set the tone for what followed thereafter.

87. I do not consider that the authority of *Shodlok* provides any real support for Dr. Ardron's argument that alleged failings showed he looked at individually. That case was not concerned with gross negligence or indeed gross misconduct in the employment context, or whether it was permissible to look at a doctor's conduct in relation to a single patient as a whole. In *Shodlok*, there was an attempt to aggregate the doctor's non-serious misconduct on 6 separate occasions, involving 5 different individuals, into a case of serious misconduct for the purposes of proceedings before the General Medical Council. It was in that context that the Court of Appeal decided not to opine on whether the approach was permissible, whilst indicating that it might be permissible on unusual facts. I do not consider that the case establishes any general principle, or that is has any application in the present context.

88. Since I do not accept the validity of the approach of considering each failing individually, I do not need to address the question of whether any individual failing, standing alone, would cross the threshold so as to provide a sufficient case of gross misconduct. Had the issue arisen, I would have been inclined to say that the allegation of failure to prescribe medication would have been sufficient.

89. In reaching my conclusion that there is a sufficient case, I have taken into account the potential arguments that Dr. Ardron may be able to advance as to context including mitigation. Although Lord Hodge in *Chhabra* used the language "when taken at the highest", I accept that this does not mean (as Mr. Hyam put it in argument) that one should look only at the "plum" parts of the Trust's case and ignore those parts which were "duff". It may be that in some cases the Court would be able to see that there was (for example on facts which were undisputed or realistically incapable of dispute) such a clear answer to a case of gross misconduct, or such powerful mitigation, that the charge could not succeed. However, I do not consider that the Court on an application such as the present should be drawn into any attempt to resolve disputed facts. That is a matter for the panel. Furthermore, in many if not most cases, where a charge of gross misconduct can properly be brought against a doctor, there will be facts or factors which the doctor can pray in aid in his or her favour – whether of context or mitigation – which will have to be considered as part of the panel's decision-making process. Whilst allegations of gross misconduct are serious, that does not mean that the only cases that can properly go to a hearing are those where the facts are all one way (i.e. in favour of the employer) and where there is little or nothing to be said on the doctor's behalf.

90. Ultimately, the panel will need to consider the arguments on both sides. It will need to weigh Dr. Ardron's arguments as to context and mitigation in the context of the Trust's arguments that there were very serious breaches of professional duty over a

period of three months. None of the matters of context or mitigation, relied upon in the course of Mr. Hyam's argument, struck me as being so forceful as to make the Trust's decision to pursue these proceedings unlawful or a breach of contract. There is ample scope for the Trust to respond to those various points with arguments of its own. For example, Dr. Ardron relied in relation to the poor record keeping upon difficulties with the operation of a computer within the Healthcare Wing. However, the Trust's response was in essence that these difficulties were exaggerated, in view of the proximity of Dr. Ardron's office (and computer) to the Healthcare Wing, and that in any event the poor record keeping occurred over a number of months and in circumstances where other doctors were able to record more detailed and comprehensive notes. Similarly, the Trust pointed out that there were responses to Dr. Ardron's case that it was only possible to see JO through hatch reviews: for example, other doctors were able to meet with him in a conventional setting.

91. As I have indicated, there may be cases, particularly of a one-off incident, where there is obvious and significant mitigation that it can readily be seen that it is sufficient to reduce conduct which would otherwise be gross misconduct to something less serious. But in the present case I agree with the Trust that the mitigation is fact sensitive and that there are disputes of fact which require exploration. For example, is Dr. Ardron's evidence entirely accurate and how much weight should be applied to it? The prison environment is obviously difficult, but it was Dr. Ardron's role to work in a difficult environment. Did the computer difficulties exist to the extent alleged and, even if they did, should Dr. Ardron nevertheless have made notes in her office. Is the fact that the Healthcare Wing may have been busy sufficient to reduce this from gross misconduct or something lesser? These are all matters which, in my view, are to be evaluated by the panel, as indeed are the other matters relied upon as 'context'.

92. Nor did I consider that there was any force in Mr. Hyam's point that neither Dr. Wijetunge nor Dr. Parrot had characterised Dr. Ardron's conduct as being grossly negligent, or gross misconduct, or wilful default. The decision of the Court of Appeal in *Chhabra* makes it clear that it is open to the case manager to apply this characterisation if that is appropriate on the evidence which emerged from the investigation. It was no part of Dr. Wijetunge's remit or Terms of Reference to express a view on whether any breach of professional standards should be so characterised. Indeed, given that the investigator's role is to ascertain the facts in an unbiased manner, it would seem more appropriate for any characterisation of the facts to be a matter for the case manager. As for Dr. Parrott: her role was to assist and advice Dr. Wijetunge, and it was no part of that role to review all the factual material or express a view as to the characterisation of any breach of professional standards.

93. Accordingly, I conclude that, in relation to Dr. Ardron's alleged failings concerning JO, the referral of a gross negligence case to a panel, pursuant to the Trust's letter of 20 March 2018, is not a breach of contract by the Trust. However, there remain a number of other aspects of Dr. Ardron's case that require resolution.

E2: The criticisms of Dr. Angus's approach and his alleged misdirection

94. As summarised in Section C above, Dr. Ardron made a number of other criticisms of the approach taken by Dr. Angus. The principal criticism was that he had not applied a test of "gross negligence", but had applied a lower "negligence" standard.

95. There was a superficial attraction to this argument (albeit that I did not consider that it led anywhere) in that the expression "gross negligence" does not appear in Appendix 3 of the Trust's Disciplinary Procedure, or in the notes of the decision-making minutes, or in the MSC. The absence of that expression in Appendix 3 serves to explain their absence from the later documents.

96. However, it was equally plain on a fair reading of both the decision-making minutes, and the MSC, that this was a case which did not involve an isolated act of negligence, but rather repeated acts of alleged negligence in different, albeit related, contexts over the 3 month period when JO was in the care of Dr. Ardron. It is also clear that the context of those acts of alleged negligence was the lack of care of a vulnerable young person, and his eventual suicide. In these circumstances, Dr. Angus did not need to ask himself the question: am I dealing with a case where there was (to use the expression in *Sandwell*) very considerable negligence? It is obvious from the notes of the January meeting, and then the length and content of the MSC, that Dr. Angus thought that he was.

97. Dr. Angus confirmed in evidence that he understood that this was the position. In his second witness statement, he said that he accepted that an isolated incident or a small number of incidents of negligence would not have led to a case to answer for gross misconduct. But in the present case he considered that he was dealing with a significant number of failings over a period of time which "when considered as a whole, are very serious indeed and certainly in my view raise a case to answer that such conduct was either grossly negligent or a wilful failure to comply with the relevant professional codes".

98. In his oral evidence, he said was that he had only ever referred one other case to a disciplinary panel. He explained that there was 3 hours of discussion at the January 2018 meeting, and then a further 1½ hours at the later February meeting, and that both he and the other participants were well prepared for those discussions. He said that the discussion was around the "totality" of the concerns; not just their accumulation, but how they interrelated. He said that it was not that there was "this concern and this concern"; but that all of the concerns interlinked; and that there were "the number of errors and the period of time". In reaching his decision, he therefore looked at all the concerns, "how many there were, and the longevity of them".

99. It seems to me that, given the context, Dr. Angus's evidence as to his approach is inherently probable and I accept his evidence as to how he approached his decision. I therefore do not consider that there was any material 'misdirection'.

100. In any event, I was not persuaded that it was appropriate to apply the concepts of 'misdirection' in the present circumstances. The present case is not an appeal or review of the decision of a lower tribunal, nor is it a case where public law principles apply. The issue is whether or not the Trust was in breach of contract in acting on its letter of 20 March 2018 and pursuing a case of gross negligence against Dr. Ardron. The case manager's role is to decide whether or not there is a case that could and should properly go before a disciplinary panel. If the case manager decides that there is such a case and (as I have held) there was indeed a sufficient case, then I do not consider that the Trust would be in breach of contract even if some aspects of Dr. Angus' reasoning process could be criticised.

101. Furthermore, even if there were any force in the 'misdirection' argument, I would not have considered it appropriate to grant injunctive or other relief in circumstances where (i) there is a sufficient case of gross negligence to go to a panel, and (ii) Dr. Angus is clearly of the view that this is a case of very serious negligence which potentially warrants dismissal. If there were a misdirection, then that would not be the end of the disciplinary process. The case would have to go back to Dr. Angus for reconsideration. But it is obvious from Dr. Angus's evidence that he would make exactly the same decision (i.e. to refer the matter to a disciplinary panel), as indeed in my judgment he is entitled to do. Dr. Angus clearly regards the alleged misconduct of Dr. Ardron as very serious.

102. There were various other criticisms of Dr. Angus' approach. It was suggested in opening that Dr. Angus had carried out his own investigation, rather than relying upon the investigation carried out by Dr. Wijetunge. But Dr. Angus denied this, explaining that his work had involved detailed consideration of what Dr. Wijetunge had said, including the appendices to his report. The only additional materials which Dr. Angus had considered were JO's medical records, which were referred to in Dr. Wijetunge's report but which (as is common) were not exhibited. I see no valid criticism of Dr. Angus's approach. I also considered that it was apparent from the minutes of the January 2018 meeting, and the Management Statement of Case, that Dr. Angus's analysis was firmly grounded in the findings and evidence obtained by Dr. Wijetunge.

103. There were three specific matters pleaded in the Particulars of Claim (paragraph 28 (d)) where it was alleged that Dr. Angus had raised matters not investigated by Dr. Wijetunge for consideration at the hearing or in respect of which no evidence had been gathered by Dr. Wijetunge: See paragraph [56] above. One of these was Dr. Angus's statement in the MSC that ward reviews did not occur although Dr. Ardron was in the prison. I address this in detail in the Section E3 below. The other matters were as follows.

104. First, page 8 of the MSC stated that "the investigation report and appendices have not set aside concerns with regard to the number of patients Dr. Ardron saw on a weekly basis in the context of ward rounds". In their opening submissions, the Trust said that this was not "raising a matter, it is simply an observation of the Case Manager – it does not feature as one of the allegations that Dr. Ardron faces which are set out on page 15 of the MSC." As I understand it, therefore, the Trust does not seek to pursue any general allegation that insufficient numbers of patients were seen on a weekly basis; as distinct from the allegation (see below) that ward rounds were not carried out at all on a number of occasions, and the allegations (see above) relating specifically to the way in which JO was seen and treated. It is therefore unnecessary to explore the extent to which (as Dr. Angus maintained in his evidence) this more general issue was the subject of evidence to Dr. Wijetunge. Even if this particular passage went beyond the evidence in Dr. Wijetunge's report and appendices, this would in my view be a minor irregularity which would not warrant injunctive relief: see *Chhabra* paras [39] – [40].

105. Secondly, page 16 of the MSC contains a very brief comment in relation to one of the matters which Dr. Wijetunge considered as a point of context "in regard to the prison setting and resources available to Dr. Ardron that should be considered when looking at the areas where she did not meet professional standards of good practice'. The point of context was: "the high proportion of patients awaiting transfer to hospital

from the Healthcare Wing whilst JO was a patient there". Dr. Angus's comment was that "such patients are clinically understood and whilst they await transfer, this reduces the turnover of patients on the ward". It seems to me, as the Trust submitted, that this is a statement of the obvious. If a patient is awaiting transfer to a psychiatric unit, it follows that he has already been diagnosed as suffering from a mental disorder of a nature or degree which makes it appropriate for him to be detained in hospital for medical treatment. It also follows that no person will be coming into the ward to take his place until he has actually been transferred. Dr. Angus said in cross-examination that he had in mind evidence from Dr. Ardron that new patients create additional work: therefore if there are a high proportion of existing patients who are awaiting transfer, then this may mean that a doctor has to spend less time with them, and consequently this particular point of context was not a powerful mitigating factor in Dr. Ardron's favour. Again, this seems to me to be a fairly obvious point.

106. In my view, Dr. Angus in the relevant passage was simply making an observation (which seems to be a statement of the obvious) on one potential point of mitigation. This is not a case where he is raising a matter which was not investigated by Dr. Wijetunge. And even it was, it would at most be a minor irregularity which would not justify injunctive relief.

E3: Failure to carry out ward rounds

107. One of the issues raised in the 20 March 2018 letter, and the MSC, concerned Dr. Ardron's attendance at ward rounds (sometimes referred to as ward reviews). These ward rounds would ordinarily have been carried out on Wednesdays, when Dr. Ardron was at the Healthcare Wing. The circumstances relating to the care of JO and his death had given rise to concerns as to whether Dr. Ardron had regularly been carrying out her duties in this respect, and in TOR 2 Dr. Wijetunge was asked to look at the period from 4 September 2015 to 10 March 2016. This included, but was wider than, the period when JO was under Dr. Ardron's care (25 November 2015 to 12 February 2016). Dr. Wijetunge's report identified 11 Wednesdays on which, according to certain records made by the prison, ward reviews "did not occur as scheduled". He investigated each of those dates, and was satisfied that there was no breach of professional standards in relation to 6 of them: essentially, Dr. Ardron had been able satisfactorily to explain why she had not carried out the ward reviews on those days (for example on some occasions she was attending a court hearing), and the alternative arrangements that she had made.

108. This left 5 dates which had not been satisfactorily explained: these were 14 October 2015, 21 October 2015, 28 October 2015, 4 November 2015 and 6 January 2016. Dr. Wijetunge's conclusions were in the following terms:

> 11.4 Dr Ardron did not attend Ward Review as scheduled on 11 occasions. Based on the standards set out In the General Medical Council's "Good Medical Practice", the available evidence indicates that she had met professional standards of good practice on 6 of these occasions. For the remaining 5 occasions, there is insufficient evidence to indicate whether she was meeting professional standards of good practice.
>
> 11.5 On 30 September 2015, 9 December 2015, 8 February 2016 and 15 February 2016, the evidence available indicates that Dr Ardron had made

> arrangements to ensure cover for the Healthcare Wing was being provided by a medical colleague whilst she was away. Thus, on these occasions, she met professional standards of good practice.
>
> 11.6 On 18 November 2015, Dr Ardron was not able to carry out a Ward Review due to being on sick leave. "Good Medical Practice" makes reference to doctors protecting patients and colleagues from any risk posed by their health. Dr Ardron has also stated that she came in and carried out clinical work at the Healthcare Wing on the following day. Thus, on this occasion, based on the available evidence, she met professional standards of good practice.
>
> 11.7 Although Dr Ardron was not able to carry out a Ward Review on 27 January 2016 due to training commitments, she did carry out one on the following day. "Good Medical Practice" states that doctors must work "collaboratively with colleagues to maintain or improve patient care. In order to reschedule the Ward Review in view of her training commitments on 27 January 2016, she would have needed to liaise with colleagues on the Healthcare Wing. In doing this, she met professional standards of good practice on this occasion.
>
> 11.8 On 14 October 2015, 21 October 2015, 28 October 2015, 4 November 2015 and 6 January 2016, there is insufficient evidence to state whether Dr Ardron was meeting professional standards of good practice on these occasions when no Ward Review took place.
> It should be noted that when interviewed on 12 June 2017, Dr Ardron said that as the Trust had taken away her access to the clinical records on SystmOne, her ability to clearly determine which patients she may have seen on these dates was adversely affected.

109. This aspect of the case against Dr. Ardron was addressed in the MSC in the following terms.

> TOR 2 - For ward reviews that did not take place between 4 September 2015 and 10 March 2016 to establish why that was the case and did Dr Ardron's conduct in this area meet professional standards of good practice.
> TOR 2 to be considered at the
> disciplinary hearing (attendance at ward rounds).
>
> These dates cover the period Mr JO was under Dr Ardron's consultant care.
>
> It was noted that on the 18 November 2015, Dr Ardron was off sick. Section 10.40 lists the dates Dr Ardron said she had been at HMP Lewes but could not recall what clinical work she had done. These are the dates of most concern: 14 October 2015, 21 October 2015, 28 October 2015, as Dr Ardron was In the Prison and ward reviews did not occur although Dr Ardron was in the Prison.

> From 14 October 2015 to 18 November 2015, for five out of those six weeks no ward review took place therefore Dr Ardron did not undertake the duties of her job.
>
> The balance of responsibilities across the staff group for ward reviews to take place was considered. There is still an expectation for Dr Ardron to conduct her reviews and undertake the duties of her job.
>
> Regular ward reviews did not take place. The case investigator's report highlights that the external expert advisor to the case investigator, Dr Parrott and the findings from the PPO report, in line with Good Medical Practice, expect these to take place.
>
> Dr Ardron's mitigation that there was a lack of Prison Staff to unlock the cells has been considered but regardless there is an expectation she would have regularly reviewed all of the patients under her care and kept a contemporaneous record of her clinical
> findings and ongoing review and treatment planning, including interactions with patients, specifically those with Mr JO undertaken through his cell hatch.

110. The Trust's case in relation to the ward rounds is, as it seems to me, in a somewhat different category to the case which I have previously considered relating to Dr. Ardron's care (including related record keeping) of JO. This is because the first four of the dates in issue pre-date the time when JO arrived in the Healthcare Wing and came under Dr. Ardron's care, albeit that they were all within 6 weeks of the time that he arrived. It was only the final date (6 January) which was within the period that JO was there.

111. The arguments in relation to the alleged failure to carry out ward rounds were also rather different. There appeared to be no dispute (at least for the purposes of this hearing) that ward rounds were an important part of Dr. Ardron's responsibilities, and that an unexplained failure to carry out a number of ward rounds could potentially be the subject of a gross misconduct case. Rather, the issue was whether there was a sufficient basis in Dr. Wijetunge's report for the Trust to make the allegation that there had been a failure to carry out ward rounds on the relevant occasions. In that respect, Dr. Ardron submitted that the allegation in the MSC that no ward review had taken place during 5 of the 6 weeks from 14 October to 18 November 2018 was "not supported by the evidence in the investigation report which is simply that there was no sufficient evidence (i.e. a documented clinical record) to demonstrate that the ward review did take place on the Scheduled dates – see Wijetunge conclusion at 11.8)." The Trust submitted, however that Dr. Wijetunge had concluded that the ward rounds had not taken place, but that he was not satisfied (in relation to the 5 occasions in question, in contrast to the other 6 occasions) as to whether or not there were good reasons for non-attendance.

112. In my view, it is important to examine this issue by recalling that the role of the case investigator is to discover whether there is a "prima facie" case of misconduct. Here, having considered the evidence – including the relevant prison records – Dr. Wijetunge concluded in paragraph 11.4 that Dr. Ardron "did not attend Ward Reviews

as scheduled on 11 occasions". He goes on to say in that paragraph that there 6 occasions when she did meet professional standards of good practice. Paragraphs 11.5 to 11.7 explain why he was able to come to that conclusion: in essence because there were valid reasons for her non-attendance, and alternative arrangements had been made. But in relation to the other 5 occasions, he said that there was "insufficient evidence to indicate whether she was meeting professional standards of good practice". This was because he had not been provided with sufficient evidence to enable him to conclude that on those occasions there was a valid reason for non-attendance, or that alternative arrangements had been made.

113. It seems to me that these findings do amount to a "prima facie" case of misconduct. I also consider that Dr. Angus was entitled, in the light of paragraph 11.4 and the more detailed discussion of TOR 2 earlier in Dr. Wijetunge's report, to proceed on the basis that there was a sufficient case that there had indeed been non-attendance on ward rounds on the 5 relevant occasions. It will be of course open to Dr. Ardron to rebut this case (while it is only a "prima facie case) and to argue at the hearing that this prima facie case should not lead to finding of any misconduct for various reasons, including those canvassed during the course of argument; for example, because there is evidence that on 2 of the occasions in question she did see prisoners in the Healthcare Wing; or because the underlying records are consistent with the proposition that on some of the relevant occasions the absence of prison staff prevented her from carrying out ward rounds; or because the prison records are not reliable; or because she has not been afforded sufficient opportunity to examine all the relevant records. It seems to me that all of those matters are for another day, but that the Trust has not committed a breach of contract in putting these matters before the panel.

114. Before leaving this issue, I should mention one development which occurred subsequent to the MSC. Dr. Ardron's non-attendance on 27 January 2016 was explained as being due to training commitments, and this was accepted by Dr. Wijetunge in paragraph 11.7 of his report. However, it now appears that the relevant training day was 6 January 2018 (one of the 5 days relied upon by Dr. Wijetunge) and therefore Dr. Ardron's non-attendance on that day appears excusable. It may be that the Trust will in due course not pursue its case in relation to 6 January, although this may depend upon whether alternative arrangements were made by Dr. Ardron to cover for her absence. Or it may be that the Trust will now pursue a case relating to 27 January (as Mr. Jupp's closing submissions indicated), on the basis that her absence on that day has not been explained – although I note that, in paragraph 11.7, Dr. Wijetunge concludes that Dr. Ardron did carry out a ward review on the following day. I do not consider, however, that it is necessary or appropriate for the court to start to micro-manage this aspect of the case against Dr. Ardron.

E4: Breach of the implied contractual term of trust and confidence

115. It also seems to me that the Trust has a sufficient case in relation to breach of the implied term identified in *Mahmud v Bank of Credit and Commerce International SA* [1998] AC 20, 45-46, for the same reasons that there is a sufficient case in relation to "gross negligence". Indeed, the case in both respects is essentially the same; namely that the acts amounting to gross negligence meant that Dr. Ardron was acting in a manner calculated or likely to destroy or seriously damage the relationship of trust and confidence between her and the Trust. In the course of his closing argument, Mr.

Jupp acknowledged that the Trust's case in relation to breach of this term did not add anything to the gross negligence case, except in the event that I were to accept Mr. Hyam's submission that it was impermissible (in the context of gross negligence) to look at Dr. Ardron's alleged failings as a whole. I have already rejected the argument that gross negligence cannot be viewed by looking at Dr. Ardron's conduct as a whole. However, even if that conclusion were wrong, I agree with the Trust that there is no difficulty in saying that there can be a breach of the implied term over a period of time.

116. It is appropriate at this stage also to address Dr. Ardron's argument that the absence of a sustainable case on breach of trust and confidence is demonstrated by the fact that she was not suspended from working by the Trust, and indeed has continued to work for the Trust and to see patients since April 2018 notwithstanding the decision to bring disciplinary proceedings and notwithstanding the alleged failures set out in the MSC. These matters were also relied upon, as I understood Dr. Ardron's case, as showing that her conduct cannot have crossed the threshold so as to amount to gross misconduct or to make dismissal a potentially available sanction.

117. I did not think that there was any force in these submissions. Dr. Ardron returned to work, after absence through illness, in April 2018. As explained in the letter to her from Dr. Angus dated 18 April 2018, additional supervision and support were to be put in place "to support you in your return to work and to provide assurance around certain tasks". The areas identified for additional assurance were: attendance at ward rounds and clinical reviews; that all patients under her care as an in-patient consultant have a weekly entry made by Dr. Ardron in their Care Notes following her review; and assurance that all any section papers completed by Dr. Ardron contained the key information with regard to all risk factors. Dr. Angus explained in his evidence that consideration had been given to excluding Dr. Ardron from work, because of significant concerns about Dr. Ardron's practice. However, the issues did not relate to whether she was a capable clinician: she was. The issues were about whether she was actually doing the job that she was employed to do. Dr. Angus therefore wanted to be assured that she was attending ward rounds, seeing all patients each week, documenting matters properly, thinking about ongoing risk factors and review, and prescribing. The processes put in place involved 3 or 4 different people, including Dr. Noon and the ward manager. Broadly they aimed to check that Dr. Ardron was seeing patients each week and assessing them personally.

118. Thus, specific measures have been put in place to monitor Dr. Ardron, and these would not normally have existed for a consultant psychiatrist of her experience. Furthermore, there are restrictions contained in MHPS as to the circumstances in which a doctor can be excluded from work: temporary restrictions must be considered first. It is also important to remember that, at the present stage, the case against Dr. Ardron remains just that: a case which has yet to be proven. Against this background, I do not consider that, for the purposes of the issue which I need to resolve, any conclusion favourable to Dr. Ardron can be drawn from the fact that she has continued to work since April 2018 or indeed at any relevant prior time. Equally, as made clear in Dr. Angus's letter dated 18 April 2018, the existence of the measures which have been put in place "to provide support to you and to provide assurance

with regard to the safety of our patients" should not be seen as prejudging the outcome of the disciplinary process.

E5: Wilful breach of professional code of conduct

119. The 20 March 2018 letter and the MSC both advance a case that the allegations, if founded, could constitute "Wilful breach of professional code of conduct". The Trust's essential case in that regard is that Dr. Ardron was a capable clinician; she breached her professional responsibilities in a number of different ways over a period 12 weeks; and that it can be inferred from the number and nature of the breaches that she must have appreciated that she was not fulfilling those responsibilities.

120. I have considerable doubt as to the strength of the Trust's case that Dr. Ardron was acting wilfully in breach of her professional code of conduct. It seems to me that to be far more probable – particularly bearing in mind the very positive testimonials provided by Dr. Ardron's colleagues – that a tribunal would find that any failures were inadvertent negligent (whether or not amounting to gross negligence) rather than in the nature of deliberate misconduct. However, I cannot rule out the possibility that a panel could draw the inference which the Trust seeks to draw in relation to the treatment of JO when considered as a whole. Moreover, if ward rounds were missed on a number of occasions, and this was done without valid reason, I cannot rule out the possibility that a panel would find that this was deliberate. Even if the Trust's case in relation to wilful breach at present appears to be rather weak, I do not consider that I can conclude that there is no sufficient case to go before the panel.

121. For the above reasons, Dr. Ardron's claim for a final injunction is dismissed, and the injunction previously granted on 18 June 2018 will not be continued