Neutral Citation Number: [2025] EWHC 2023 (KB)

Case No: KB-2025-001016

**IN THE HIGH COURT OF JUSTICE**
**KING'S BENCH DIVISION**

LIVERPOOL DISTRICT REGISTRY

Date: 31 July 2025

**Before** :

**MR JUSTICE SHELDON**

- - - - - - - - - - - - - - - - - - - - -

**Between :**

**Dr MN**

**Claimant**

**- and -**

**NHS FOUNDATION TRUST L**

**Defendant**

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**Mr Mark Sutton KC, Ms Nicola Newbegin** (instructed by **DWF Law**) for the **Claimant**
**Mr Simon Gorton KC, Mr Jack Mitchell** (instructed by **Hill Dickinson LLP**) for the **Defendant**

Hearing dates: 7-9 July 2025

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# Approved Judgment

This judgment was handed down remotely at 10.00am on 31 July 2025 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

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MR JUSTICE SHELDON

## Mr Justice Sheldon:

1. Dr MN is a Consultant in Diabetes and General Paediatrics employed by NHS Foundation Trust L (which I shall refer to as "the Trust"). Dr MN has brought a claim for breach of contract against the Trust, seeking declaratory and injunctive relief to prevent the Trust from breaching his contract of employment with respect to an investigation that they are carrying out, and to the next steps that may be contemplated by the Trust following the conclusion of the investigation.

2. Case management of these proceedings has been carried out by Garnham J and Jeremy Johnson J, both of whom have made orders with respect to maintaining Dr MN's anonymity. The underlying rationale for the grant of anonymity in these proceedings is that Dr MN gave evidence in the first criminal trial of Lucy Letby, and was granted lifetime anonymity by the trial judge, Goss J. So as to maintain Dr MN's anonymity, it is also necessary for this judgment to refer to certain other individuals by the use of ciphers or in generic terms.

3. The issues in this case were identified by the parties as:

> "1. Whether policy E.27 is incorporated into the employment contract.
>
> 2. Whether the following provision in Policy E27 Appendix A at paragraph 1.6 is apt to be given contractual effect:-
>
> The **Medical Director** will act as the **Case Manager** in cases involving Clinical Leaders ie Clinical Directors and Service Group Leads and consultants and may delegate this role to a senior manager to oversee the case on his or her behalf in other cases.
>
> 3. Whether by appointing and/or delegating Ms Y to undertake the role of Case Manager in C's case, D has acted (and continues to act) in breach of Policy E27 Appendix A at paragraph 1.6.
>
> 4. If issues (1) - (3) are determined in favour of D:
>
> (a) whether, by appointing Ms Y as Case Manager and/or delegating the role of Case Manager to her, D has acted (and continues to act) in breach of the implied terms of the employment contract.
>
> (b) Whether, by authorising Ms Y to continue to undertake the role of Case Manager, in circumstances where she has provided evidence to the Thirlwall Inquiry in relation to matters related to the subject matter of D's ongoing internal investigation, D has breached (and continues to breach) the implied terms of the employment contract.
>
> 5. If the Investigation Report identifies concerns which relate to C's conduct and/or capability, is D required to implement the

> procedures set out in the E27 Policy at Section 3 and/or Section 4 before taking action in relation to C's employment.
>
> 6. If C establishes a breach of the express and/or implied terms of the employment contract, should the Court exercise its discretion to grant declaratory or injunctive relief and if so on what terms?".

Factual Background

4. Dr MN worked at the Countess of Chester Hospital ("COCH") as a Paediatric Registrar, serving in the same clinical team on the Neonatal Unit as Lucy Letby. After leaving COCH, Dr MN started working at Hospital X, ("the Hospital"), in a *locum* capacity. On 1 July 2018, Dr MN was employed by the Trust as a substantive Consultant.

5. In December 2016, Dr MN sought to arrange for Lucy Letby to carry out a period of supervised observation at the Hospital. The precise details of Dr MN's involvement in these arrangements forms part of the investigation that he is currently subject to, and it would not be appropriate for me to make any findings about what actually took place. It is sufficient for present purposes to say that Lucy Letby did attend supervised observational visits at the Hospital on 3 or 4 occasions. Further, that in advance of doing so the Hospital sought, and COCH provided, pre-employment checks of Lucy Letby.

6. Dr MN provided the police with assistance with their investigation into Lucy Letby, and gave evidence at the first of her criminal trials. Special measures were put in place to protect his identity. On 18 August 2023, after the first trial, Lucy Letby was convicted of the murder of seven babies and attempted murder of six others at COCH between 2015 and 2016. After the conclusion of the first trial, Dr MN contacted the Trust's Deputy Chief Medical Officer to inform him of his involvement in the trial and of Lucy Letby's observership at the Hospital. This information was shared with a small number of senior personnel at the Trust. A couple of days later, Dr MN met with Mr Z the Trust's Chief Medical Officer, and the Trust's Chief Nursing Officer. Some wording for a letter was prepared by Mr Z after that meeting. The draft was obviously not complete as it contained a number of matters that needed to be filled in.

7. The draft set out a chronology of Dr MN's involvement in arranging the observership for Lucy Letby. It stated that:

> "Given the information and the supporting evidence I am content that you had no knowledge of the circumstances surrounding LL at the time of the visits and that the [Hospital's] processes were followed and that the COCH did not inform [the Hospital] of any concerns in respect of LL that would have led [the Hospital] to refuse the offer of supervised visits to [the Hospital]".

8. In his witness statement for the trial before me, which was not challenged by Dr MN, Mr Z stated that a few days after his meeting with Dr MN a complaint was received which "changed the situation significantly. Accordingly, we decided not to send this letter, but rather to consider how we should approach the evolving situation". This evidence was consistent with answers given by other Trust employees in cross-

examination. I have no reason to doubt that it was a truthful explanation of why the letter was not sent.

9. The complaint that Mr Z referred to was received on 29 August 2023. The mother of Baby N wrote to the Trust complaining that Dr MN had

> "broke[n] patient confidentiality on numerous occasions discussing my son via email facebook and other platforms with the nurse Lucy Letby, he discussed my son and passed on his condition whilst he was still on the [neonatal unit at COCH] and when he had been transferred to [the Hospital] due to her attack on him, there was no legal basis for him for breaching confidentiality, he also shared confidential emails which were meant to be between consultants only with her".

10. After the first trial of Lucy Letby, there was media reporting of her placement at the Hospital in both local and national newspapers. On 19 October 2023, Terms of Reference for the public inquiry headed by Lady Justice Thirlwall ("the Thirlwall Inquiry") to examine events at COCH and their consequences were published.

11. On 23 January 2024, Dr MN was informed that the Trust intended to undertake a formal investigation. He was told this in person, and was also provided with a letter from Ms Y, who had been appointed as the "Case Manager" for the investigation. Ms Y was the Trust's Director of Corporate Affairs. The letter from Ms Y stated that:

> "Formal investigation into Lucy Letby's visits to [the Hospital] and your involvement with Child N
>
> I am writing to inform you that following a variety of concerns that have been raised at Executive and Board level, a decision has been made to launch a formal investigation into the circumstances surrounding Lucy Letby's visits to [the Hospital] in 2017.
>
> In addition, a formal complaint has also been made by the mother of Child N about your involvement with her son while you were working at the Countess of Chester Hospital.
>
> Given the sensitivity across the NHS about all aspects of Miss Letby's career ahead of the planned statutory public inquiry, we consider there are grounds for us to investigate the full facts surrounding your judgment, decision making and actions at that time.
>
> To be clear, the investigation is not to be carried out under the Trust's local MHPS policy, Handling Concerns about the Conduct, Performance and Health of Medical and Dental Staff as these events do not involve matters of conduct or performance. However, the issues that have caused sufficient concern to warrant this investigation go to the heart of your employment relationship and contract with the Trust.

> The investigation will be a fact-finding process to gather all the relevant information about these events. The process will afford you every opportunity to explain your actions and decisions and it will be conducted objectively and fairly. Once the investigation is complete, we will evaluate its findings and consider what action, if any, we should take.
>
> I must inform you that if we conclude that you have fallen short of the high standards we expect of our employees, there is a possibility that the subsequent process may result in your dismissal".

It was also explained that:

> "given the length of time since the relevant events and their uniqueness, we do not propose at this stage to exercise our right to exclude you, particularly as the concerns do not relate to your clinical practice and there is no risk to patient safety. That said, exclusion may still be considered as a necessary option during the process".

12. Appended to the letter to Dr MN was a document setting out the scope of the investigation. Ms Y had commissioned, on behalf of the Board of the Trust, a specialist external consultancy – *Verita* – to conduct the investigation. The Terms of Reference for this investigation were described as

> "to establish the full facts relating to:
>
> • Dr [MN]'s prior knowledge of concerns about LL [Lucy Letby] and events at CoCH in 2015 and 2016
>
> • Dr [MN]'s involvement in facilitating LL's visits to [the Hospital] in 2017, and
>
> • Dr [MN]'s role with LL in the care of Baby N, and what communication Dr [MN] shared with LL while working both at CoCH and at [the Hospital]".

13. The "Key areas of the investigation" involved three main areas of scope:

> **"Dr A's prior knowledge**
>
> • The investigator will establish what Dr MN knew of concerns at CoCH with regard to neonatal adverse events and deaths both whilst employed as a registrar there and subsequently as a locum consultant paediatrician at [the Hospital ].
>
> Specific areas to include as a minimum:
>
> i. What did Dr MN know of the concerns about LL before or after leaving CoCH?

ii. What were the basis of those concerns?

iii. Who expressed them and in what context?

iv. Did LL inform him of the suspicions levelled at her and did they discuss those suspicions?

v. Was he aware that she was being moved to the day shift and the reason why?

vi. Did he subsequently know of her move to non-clinical duties and if so when and why?

vii. Was he aware of her grievance against COCH and did he have any involvement in it or the associated process and its outcome?

**LL's visits to [the Hospital]**

• The investigator will establish Dr MN'S involvement in facilitating LL's visits to [the Hospital] in late 2016 and early 2017.

Specific questions for Dr MN will, as a minimum, cover the following:

i. How many visits did LL undertake and when?

ii. Did Dr MN accompany her for the duration of every visit?

iii. What was the reason for her visit to the PICU?

iv. What did Dr MN convey to management and clinical colleagues with regard to any concerns about LL (formal or informal) before inviting her to [the Hospital]?

v. What risk assessment did Dr MN carry out in relation to LL's visits before inviting her to [the Hospital]?

vi. Following LL being arrested did Dr MN raise with his managers his previous contact with LL and her visits to [the Hospital]? If not, why not?

**Baby N**

• The investigator will establish what involvement Dr MN had with LL in her care of Baby N whilst on the NNU at the CoCH and any associated communications between them.

> • The investigator will establish what subsequent communications Dr MN had with LL with regard to Baby N once Dr A became employed at [the Hospital]
>
> •The investigator will establish what access Dr MN had to Baby N's clinical records since working at [the Hospital] and the reasons for that access".

14. It was also stated that

> "Should any issues arise during the investigation that raise concerns about patient safety, the wellbeing of participants, or that require investigation elsewhere, the investigator will immediately alert the commissioner".

15. The reference to "MHPS" in the letter of 23 January 2024 to Dr MN is to the policy of the Department of Health entitled "Maintaining High Professional Standards in the Modern NHS". This provides a framework for handling concerns about doctors and dentists in the NHS. The Directions on Disciplinary Procedures 2005 require all NHS bodies in England to implement the framework within their local procedures. For NHS Foundation Trusts (which is the legal status of the Trust in this case), it has been agreed with Monitor (the statutory regulator of Foundation Trusts) that the framework should be issued as advice. I shall set out further detail about MHPS later in this judgment.

16. Dr MN has not been interviewed for the purposes of the investigation. For some of the period, Dr MN has been extremely unwell or suffering from the after-effects of treatment for a medical condition. There has also been considerable correspondence between the parties and their respective lawyers. I shall set out some of the correspondence so as to illustrate the areas of dispute between the parties that are now captured by the list of issues that are before the Court.

17. Shortly after the letter of 23 January 2024 was provided to Dr MN informing him of the investigation, his then legal representatives (Weightmans) questioned why the Trust was not conducting the investigation under MHPS. The response from the Trust was that the matter being investigated did not relate to Dr MN's conduct or performance.

18. Dr MN was invited to attend an interview to take place on 16 February 2024. Weightmans responded to say that Dr MN would not be attending until he had received Leading Counsel's advice as to the procedural framework governing the proposed investigation. Ms Y chased this matter up with Weightmans but no response was forthcoming. Ms Y wrote directly to Dr MN on 27 February 2024 saying that she had no option but to correspond with him, and that the lack of response was "both unacceptable and discourteous". This letter was not responded to, and on 8 March 2024, Ms Y emailed Dr MN to express her disappointment, and to issue him with "a direct management instruction" to attend for a preliminary interview, having discussed the matter with the Chair and Chief Executive of the Trust.

19. Dr MN responded immediately to apologise. He explained that new legal representatives were being engaged as Weightmans had previously represented the Trust. On 11 March 2024, solicitors at the firm DWF wrote to Ms Y to say that they were now instructed to assist Dr MN and stated that the investigation had to be

conducted under MHPS, and the approach being taken was in fundamental breach of Dr MN's contractual rights. It was explained that although it had been stated by the Trust that the events being investigated did not involve "matters of conduct or performance", this was inconsistent with other assertions made in the correspondence and in the Terms of Reference for the investigation, and that the matters being investigated fell within the ambit of MHPS. The Trust was asked to confirm, among other things, that MHPS would be followed, and that the Medical Director would act as Case Manager and would be personally responsible for determining how any investigation report should be responded to.

20. DWF also asked the Trust to confirm that the Crown Prosecution Service and the Thirlwall Inquiry were aware of their investigation and were content for it to proceed whilst criminal proceedings involving Lucy Letby were still pending and the Thirlwall Inquiry was afoot. This was responded to by Ms Y on 15 March 2024. She accepted that the Baby N matter would be of relevance to the Thirlwall Inquiry, falling within its published Terms of Reference. Accordingly, Ms Y confirmed that that aspect of the investigation would be put on hold until the Trust had confirmation from the Thirlwall Inquiry. The investigation into Lucy Letby's visits to the Hospital was regarded by the Trust as a "purely internal matter relating to [Dr MN's] role and responsibilities as our employee" and had no relevance to the criminal activities of Lucy Letby. Consequently, Ms Y said that the investigation into these matters would continue.

21. Ms Y stated that MHPS did not apply in this case as the matter was not one of conduct or performance. However, the Trust intended to apply and adhere to MHPS as part of a general obligation to treat Dr MN fairly. It was explained that the Trust had already mirrored the procedural protections provided by MHPS by, among other things, appointing Ms Y as Case Manager. It was also explained that on receipt of the investigation report, the following options would be considered by Ms Y:

> "(i) That there is in fact nothing of concern and therefore no further steps that should be taken; or
>
> (ii) That there are real concerns that go to the heart of the employment relationship between the Trust and your client that require the matter to be put to an internal hearing to consider whether your client's employment should be continued or terminated. That would not relate to your client's conduct, but rather whether the essential term of trust and confidence has been irreparably damaged by the acts and omissions of your client. A fair panel process would be followed that similarly would mirror the internal disciplinary route and safeguards under the Trust's Disciplinary Policy E5; or
>
> (iii) That there are real concerns that amount to conduct that require them to go before a formal hearing under the Trust's Disciplinary Policy; or
>
> (iv) Finally, that both issues of trust and confidence and conduct be combined in a hearing process that both follows (for conduct) and mirrors (for trust and confidence) the Trust's Disciplinary Policy".

Ms Y rejected the assertion that the Medical Director had to be the Case Manager. This was not prescribed by MHPS or E27 (the Trust's policy).

22. DWF responded on 19 March 2024. They stated that Lucy Letby's visits to the Hospital were not purely an internal matter with no relevance to the criminal investigation; they also fell within the Terms of Reference for the Thirlwall Inquiry. DWF stated that the Trust was therefore "required to seek permission from the CPS and the Inquiry before proceeding with this line of investigation."

23. Ms Y met with the secretariat to the Thirlwall Inquiry on 25 March 2024. On 2 April 2024, Ms Y wrote to Lady Justice Thirlwall. She explained that the Trust wished to undertake an internal investigation into two matters relating to Dr MN's involvement with Lucy Letby: (i) the observational visits; and (ii) the formal complaint by the mother of Baby N. Ms Y enclosed a copy of her letter to Dr MN of 23 January 2024. Ms Y stated that although Dr MN had given assurances of his intention to engage with the process, "the correspondence from his legal team has posed an explicit challenge to the legitimacy of our internal investigation on the basis that both of the above matters fall under the purview of your own Inquiry's terms of reference". Ms Y stated that the Trust disagreed with the solicitors' analysis in respect of the visits by Lucy Letby, which was viewed as "an ongoing internal employment matter", but accepted that the issue with respect to Baby N ought to be raised directly with the inquiry. Ms Y continued that:

> "We believe that the Trust has the right to look into both of these issues in the context of our contractual relationship with our employee. . .
>
> In our view, the proposed investigation is significant in terms of our ability to discharge our obligations to our patients and the public, in the context of the criminal case and the publicity that will inevitably ensue from the upcoming public inquiry. This duty equally applies to the individual complaint made by the mother of Baby N, who has expressed a clear expectation that we will provide her with a resolution to her concerns.
>
> The Trust is formally seeking the support of the Inquiry to proceed with its internal investigations".

24. The Solicitor to the Thirlwall Inquiry, Tim Suter, responded to Ms Y on 3 April 2024. He explained that the Chair was grateful to Ms Y for raising with the inquiry "the sensitive issue of the investigation" into the actions of Dr MN and for the information provided. Whether the Trust should investigate was a matter for the Trust to decide having regard to their own obligations. Mr Suter explained that The Thirlwall Inquiry had no objection to the investigation by the Trust, but alerted Ms Y to the timetable relating to Dr MN's evidence. It was anticipated that there would be some overlap between the questions asked of Dr MN by the Thirlwall Inquiry – requested under Rule 9 of the Inquiry Rules 2006 – and those raised in the Trust's investigation. The Trust was asked to defer asking Dr MN questions until after he had provided his statement to the Thirlwall Inquiry.

25. On 12 April 2024, Ms Y wrote to DWF to say that the Trust's investigation would proceed, but Dr MN would not be called for interview until he had delivered his Rule

9 statement to the Thirlwall Inquiry. With respect to MHPS, it was stated that "to regularise matters . . . The Medical Director will assume the nominal role of Case Manager but will however delegate responsibility for this to myself". This delegation was reflected in an email from Mr Z (the Chief Medical Officer) to Ms Y, in which Mr Z also stated that it was "common practice for me to devolve this role to an appropriately trained senior member of staff."

26. A letter before claim was sent by DWF to Ms Y on 18 June 2024, alleging that the Trust was acting in breach of contract. This was responded to by Ms Y on 10 July 2024. In that response, the allegations of breach were rejected. It was explained that the appointment of the Medical Director as Case Manager and then delegation to Ms Y was:

> "common practice in a busy trust with numerous MHPS cases ongoing, as the Medical Director simply does not have the capacity to act as the Case Manager for all MHPS matters. This is recognised and accepted by all relevant bodies including the BMA, HCSA and MPS. There has never been a challenge when the Medical Director delegates his functions as in this case".

Ms Y also stated that since her meeting with Dr MN in January 2024 "the Trust has been unable to make progress with matters as your client has repeatedly refused to attend for interview and you have intervened raising various legal challenges to the Trust's approach". DWF responded to say that they understood the Trust to be refusing to accept that MHPS should apply to "the entirety of the Trust's investigation process". In reply, Ms Y disputed this, saying that the Trust had agreed to do exactly that.

27. The firm of solicitors, Hill Dickinson, wrote to DWF on 5 August 2024 to say that they had been instructed by the Trust. They stated that the Trust was clear at the outset that its preliminary assessment of the situation was that MHPS was not applicable to the matters being investigated. The issue was one of "trust and confidence" arising from the facilitation by Dr MN of Lucy Letby's visits and the precise circumstances and knowledge available to him at the time of those visits. This had the potential to raise questions around implied duties such as trust and confidence "and/or give rise to reputational issues" for the Trust. Nevertheless, the Trust was committed to following a fair and proper procedure and had taken a pragmatic approach of agreeing to apply MHPS.

28. On 8 August 2024, David Wilkinson, an Adviser to *Practitioner Performance Advice* ("PPA"), part of NHS Resolution (which is the operating arm of the NHS Litigation Authority), responded to communications from Ms Y about the concerns raised on behalf of Dr MN that the Case Manager should be the Medical Director. PPA provides advice to the NHS on managing and resolving concerns involving doctors, among other medical professionals. Mr Wilkinson explained that:

> "from my experience and knowledge, across many organisations it is relatively normal practice for the case management of Consultants and senior doctors to be delegated by the Medical Director. The key concern should be whether the Case Manager is suitably trained and/or experienced and whether there are any

> conflicts of interest that would prevent them from undertaking the role without bias.
>
> I also noted that [the Trust] . . . had the freedom to develop its own approach outside of MHPS, subject to this being appropriately set out within an agreed Policy & Procedure. As such, you should ensure that any action that you take is congruent with the requirements of your local policy".

29. On 9 August 2024, Mr Suter, the Solicitor to the Thirlwall Inquiry, wrote to Ms Y asking for records held by the Trust about Lucy Letby's work experience at the Hospital between January and April 2017. The Trust was also asked about the policies that the Hospital had applied for seeking work experience, and whether the Hospital had made any enquiries about who Lucy Letby was, her qualifications and experience, and whether pre-employment checks had been undertaken. Mr Suter also stated that it was understood that an individual who I shall refer to as BK was the Clinical Lead for Training and Development at the Hospital, and that the Thirlwall Inquiry would like to contact her to obtain a statement about her knowledge of Lucy Letby's work experience at the Hospital. Ms Y was asked if BK still worked at the Hospital or if she had contact details for her.

30. Ms Y responded on 13 August 2024. She provided email threads of the correspondence relating to Lucy Letby's visits. With respect to BK, Ms Y stated that:

> "We do not understand the particular interest in BK here; as far as we are concerned her involvement was very limited so I would be reluctant to ask her to make a statement as I suspect she can add nothing above what is contained in the email threads. We cannot find any evidence that Letby visited the operating theatres which is the part of the thread that BK was copied in to".

Ms Y also noted that the visits by Lucy Letby had not been disclosed to the mother of Baby N and the Trust was concerned as to how and when to address this given the sensitivity.

31. On 21 August 2024, a solicitor to the Thirlwall Inquiry wrote to Ms Y, attaching a Rule 9 letter. That letter was said to replicate the questions that had previously been asked of Ms Y, but in a formal request. Ms Y was also informed that it was a matter for the Trust how it wished to manage the complaint from the mother of Baby N, and that the Thirlwall Inquiry did not wish to prevent the Trust from sharing information about the visits.

32. Ms Y responded to the Rule 9 letter by producing a witness statement. The statement concluded with the following:

> "Given the seriousness of the issues, the Trust subsequently took the decision to instigate a formal investigation in order to establish a clear and definitive set of facts in relation to the visits. However, it has been unable to progress this process due to challenges made with Dr [MN's] legal representatives. This remains the case".

The statement from Ms Y in redacted form was read into the record at the Thirlwall Inquiry.

33. On 14 October 2024, Ms Y wrote to Dr MN to inform him that the internal investigation would recommence and that the Trust had agreed to treat the investigation as an MHPS case in accordance with the Trust's E27 policy "relating to your conduct (and potential gross misconduct) in addition to trust and confidence". In response, DWF wrote on 18 October 2024 to say that there was "no separate issue of trust and confidence".

34. Reference was also made by DWF to the evidence given by Dr MN to the Thirlwall Inquiry and to the fact that Ms Y had also given evidence to the inquiry. DWF contended that in light of Ms Y's evidence, her role as Case Manager had been "severely compromised" and her continuation in that role amounted to a breach of the implied duty of trust and confidence. It was contended that the role of Case Manager involved the exercise of neutral decision-making and must not involve pre-judgment, and Ms Y's actions were inconsistent with that. The Trust was asked to confirm that Ms Y would not continue as Case Manager. In a separate letter of the same date, DWF notified the Trust, confidentially, of Dr MN's medical condition and that he would not be well enough to be interviewed.

35. There was then further correspondence between the parties about Dr MN's state of health. The Trust agreed not to interview Dr MN until he was fit and able to participate. The Trust stated, however, that it would proceed with the investigation and that other material witnesses would be interviewed. On 13 February 2025, Ms Y wrote to say that she had appointed an internal Case Investigator, Mr A, a Consultant Orthopaedic Surgeon employed by the Trust, to replace *Verita*. The Terms of Reference and the "Key areas of investigation" remained substantially the same (there were only very slight edits to the original text). On 21 March 2025, Dr MN issued a claim for breach of contract against the Trust.

36. On 29 April 2025, Ms Y notified DWF that Mr A was intending to invite a number of people to participate in an investigation interview. This included Mr Z (the Trust's Chief Medical Officer). On 9 May 2025, DWF responded to say that they were "very surprised and troubled" that it was proposed to interview Mr Z. They stated that "it is of the utmost importance that no steps are taken by the Trust which may impede Mr Z's ability to act as Case Manager, should the Court determine that he is required to do so".

Witness evidence at the trial

37. At trial, oral evidence was given by Dr MN, as well as by Ms Y and Mr W (the current Chief Executive Officer of the Trust). The witness statements of Mr Wilkinson (the Adviser from the PPA), Mr A (the Case Investigator) and Mr Z (the Chief Medical Officer) were provided to the Court but not challenged by Dr MN.

38. Mr Wilkinson's witness statement, made on behalf of PPA, noted that PPA was advising on 538 cases involving Consultants. Of those, in 489 cases a Case Manager had been identified, and in 210 of those cases (43%) the Medical Director/Chief Medical Officer acted as Case Manager. In 278 cases where a Case Manager had been identified, the Medical Director/Chief Medical Officer was not acting as Case Manager. Mr Wilkinson stated that:

> "PPA is unable to establish, without undertaking a much more detailed analysis, what Trust's policies incorporating MHPS state in those cases, including whether or not they specifically provide for the Case Manager to be someone other than the Medical Director/CMO in cases involving consultants".

Mr Wilkinson also pointed out that PPA was aware that:

> "especially at larger NHS trusts, the wording of local policies sometimes specifically permits individuals other than the Medical Director to act as Case Manager for cases involving consultants".

39. Mr Wilkinson also expressed the view that:

> "If there were to be a blanket requirement for all NHS organisations to appoint the overall Medical Director (often now called the CMO) as Case Manager in cases involving consultants, that could place a very significant burden on some Medical Directors/CMOs, particularly at larger NHS organisations".

40. In his witness statement, Mr A set out his reasons for wishing to interview Mr Z (the Chief Medical Officer): they relate to a meeting held by Mr Z (and the Chief Nursing Officer) with Dr MN on 25 August 2023 which Mr A considered makes them "witnesses of fact". Further, Mr A had seen a letter that Mr Z had drafted but did not send to Dr MN following that meeting. Mr A said that he wished:

> "to ask questions related to that content; I will want to understand what Dr MN told Mr Z and [the Chief Nursing Officer] at that meeting in relation to his organisation of the Letby visits as this will contribute to the overall factual picture of what Dr MN knew, at what point in time and what he subsequently told the Trust that he knew, both in 2018 and from 2023 onwards".

41. In his witness statement, Mr W explained that he was Deputy Chief Executive until November 2024. He stated that he was involved in the discussions surrounding the selection of Ms Y as the Case Manager; and that he agreed with the then Chief Executive that Ms Y be appointed to the role, a decision with which the Chair of the Trust agreed:

> "It was a difficult and unusual situation. First and foremost, we were very concerned about preserving the anonymity of Dr MN, which Dr MN had raised with us in clear terms and informed us was the subject of a court order. The case manager therefore needed to be selected from the small group of Executive Directors who were already aware of the case as there were (and remain) Executives who are not aware of the nature of the case. There were no issues relating to the exercise of clinical skill, so we believed the case manager did not need to be a clinician. There were, however, a range of governance issues related to the

> concerns and this was Ms [Y's] area of expertise. In addition, there was to be a Public Inquiry, so there were substantial legal aspects surrounding the issues under investigation, which is also within Ms [Y's] executive remit.
>
> Ms [Y] was also very experienced in handling complex confidential matters relating to medical staff, having dealt with numerous cases over many years".

42. In Mr Z's witness statement, he described his recollection of the meeting with Dr MN on 25 August 2023: that Dr MN "had no knowledge of any potential crime that Letby may have been suspected of committing when he supported her to undertake observational visits at the Hospital in early 2017". Mr Z also referred to subsequent discussions among the small Executive group which had been set up to decide how to proceed. Mr Z referred to the need to keep the matter confidential. Mr Z also referred to "the gradual emergence of information that pointed towards a potentially different relationship between Dr MN and Letby".

43. Mr Z said that he had oversight of all MHPS cases at the Trust as part of his role as Chief Medical Officer. He explained that "The breadth of my wider responsibilities within the Trust (having responsibility for over 500 consultants and Trust doctors) make it all but impossible for me to function as the day-to-day case manager for all cases". Mr Z also exhibited statements from Medical Directors at other Trusts within the area. They all state that they regularly delegate the Case Management function to others, and only act in that role occasionally. They say that to do otherwise would be very difficult if not impossible, given the other responsibilities that they have.

44. I found that each of the witnesses who gave oral evidence to the Court did their best to answer the questions posed helpfully and truthfully. It does not seem to me that there are any issues of fact that the Court needs to determine at this trial that turn on the credibility or reliability of any of the witnesses, or that it is necessary to prefer the evidence of one witness over another where they were inconsistent.

45. Of relevance to the issues that I will need to consider, I note that in cross-examination Mr W accepted that both the concern that Dr MN may have been aware of suspicions about Lucy Letby at the time when he sought to arrange the observership for her, and the complaint about Baby N, had potential patient impact. In her evidence, Ms Y accepted that those matters might transgress the behavioural standards expected of staff; that issues around management decisions in the workplace and matters to be arranged in the workplace may say something about Dr MN's clinical competence. Further, Ms Y accepted that failures to comply with doctor-patient confidentiality could have patient safety implications.

MHPS

46. MHPS is divided into several parts. Part I deals with "Action when a concern arises"; Part II deals with "Restriction of practice and exclusion"; Part III deals with "Conduct hearings and disciplinary matters"; Part IV deals with "Procedures for dealing with issues of capability"; and Part V deals with "Handling concerns about a practitioner's health".

47. The preamble to MHPS notes that the framework builds on a number of elements including "tackling the blame culture – recognising that most failures in standards of care are caused by systems' weaknesses not individuals per se". Further, that the approach set out in MHPS "recognises the importance of seeking to tackle performance issues through training or other remedial action rather than solely through disciplinary action".

48. The introduction to Part I (Action when a concern arises) states that "The management of performance is a continuous process which is intended to identify problems. Numerous ways now exist in which concerns about a practitioner's performance can be identified". At paragraph 3, it is stated that: "All NHS bodies must have procedures for handling serious concerns about an individual's conduct and capability", defining a "serious concern about capability" as arising "where the practitioner's actions have or may adversely affect patient care".

49. Paragraph 4 provides that:

> "All serious concerns must be registered with the Chief Executive and he or she must ensure that a case manager is appointed. The Chairman of the Board must designate a non-executive member "the designated member" to oversee the case and ensure that momentum is maintained. All concerns should be investigated quickly and appropriately. A clear audit route must be established for initiating and tracking progress of the investigation, its costs and resulting action. However the issue is raised, the Medical Director will need to work with the Director/Head of HR to decide the appropriate course of action in each case. The Medical Director will act as the case manager in cases involving clinical directors and consultants and may delegate this role to a senior manager to oversee the case on his or her behalf in other cases. The Medical Director is responsible for appointing a case investigator".

It is noted that where bodies do not have a Medical Director,

> "the Chief Executive should designate a senior clinical manager to perform the role assigned to the Medical Director in these procedures and ensure that they are appropriately trained".

50. Part I of the MHPS goes on to discuss the involvement of the NCAA (now the PPA), which can provide a range of advice. At paragraph 8, it is stated that:

> "The first task of the case manager is to identify the nature of the problem or concern and to assess the seriousness of the issue on the information available and the likelihood that it can be resolved without resort to formal disciplinary procedures".

After discussion with the NCAA, the case manager "must decide whether an informal approach can be taken to address the problem, or whether a formal investigation will be needed."

At paragraph 11 it is stated that:

> "Where it is decided that a more formal route needs to be followed (perhaps leading to conduct or capability proceedings) the Medical Director must, after discussion between the Chief Executive and Director/Head of Human Resources, appoint an appropriately experienced or trained person as case investigator".

51. The role of the "case investigator" is set out in some detail. This culminates in submitting a report to the case manager. At paragraph 17, it is stated 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;
>
> • there are concerns about the practitioner's health that should be considered by the NHS body's occupational health service;
>
> • there are concerns about the practitioner's performance that should be further explored by the National Clinical Assessment Authority;
>
> • restrictions on practice or exclusion from work should be considered;
>
> • there are serious concerns that should be referred to the GMC or GDC;
>
> • there are intractable problems and the matter should be put before a capability panel;
>
> • No further action is needed".

The Trust's Documents

52. Dr MN entered into a written contract of employment with the Trust on 1 July 2018. Clause 1 of the written contract provided that his appointment was "subject to the Terms and Conditions – Consultants (England) 2003 (the Terms and Conditions) which may be amended by collective negotiation from time to time". At clause 3, it was stated that Dr MN was "a senior and professional employee who will usually work unsupervised and frequently have the responsibility for making important judgements and decisions. It is essential therefore that our trust and confidence in your ability to work unsupervised is maintained". Among other things, Dr MN agreed "to comply with your obligations under the Trust's policies, objectives, rules, working practices and protocols".

53. At clause 17.1 the following is stated under the heading "Disciplinary Matters":

> "Wherever possible, any issues relating to conduct, competence and behaviour should be identified and resolved without recourse to formal procedures. However, should we consider that your conduct or behaviour may be in breach of our code of conduct, or that your professional competence has been called into question, the matter will be resolved through our disciplinary or capability procedures (which will be consistent with the 'Maintaining High Professional Standards in the Modern NHS' framework), subject to the appeal arrangements set out in those procedures".

54. Clause 29 of the contract of employment provides under the heading "Termination of Employment" that provisions governing termination of employment are set out in Schedule 19 of the "Terms and Conditions": that is a reference to the Terms and Conditions – Consultants (England) document. Schedule 19 provides at paragraph 4 for the "Grounds for termination of employment", which are stated to include "where there is some other substantial reason to do so in a particular case."

55. The Trust's policy that was designed to be consistent with MHPS was set out in a document entitled "E27 - HANDLING CONCERNS ABOUT CONDUCT, PERFORMANCE & HEALTH OF MEDICAL & DENTAL STAFF POLICY". Under a heading "Quick Reference Guide", it was stated that:

> "This policy applies to all medical and dental staff employed either substantively or on an honorary basis within the Trust
>
> It is designed to inform all staff of the Trust's procedures, and their rights and responsibilities in relation to implementing the framework set out in 'Maintaining High Professional Standards in the Modern NHS (MHPS)'
>
> The policy does not apply to personal conduct issues. The Trust Disciplinary Policy will apply to all medical and dental staff against whom allegations of personal misconduct have been made".

It is clear, therefore, that personal conduct issues (e.g. harassment of colleagues) is not governed by E27 (this is reflected in paragraph 1.2 of the policy, as set out at paragraph 57 below).

56. The "Quick Reference Guide" also states that:

> "All concerns about conduct or capability of medical and dental staff in training will be considered initially as training issues and the appropriate Post-Graduate Dean will be involved from the outset.
>
> All allegations must be properly investigated to verify the facts so that allegations can be shown to be true or false.

> Any potentially serious concerns which may adversely affect patient care must be registered with the Chief Executive and a Case Manager appointed.
>
> When serious concerns are raised, the Trust will urgently consider whether it is necessary to place temporary restrictions on practice".

57. The Introduction to E27 provides at paragraph 1.1 that:

> "This is an agreement between . . . the Trust and the Local Negotiating Committee (Local Negotiating Committee) outlining the employer's procedure for handling concerns about doctors' and dentists' conduct, performance and health. It implements the framework set out in 'Maintaining High Professional Standards in the Modern NHS' (MHPS), issued under the direction of the Secretary of State for Health on 11 February 2005".

At paragraph 1.2 it is stated that:

> "MHPS must be followed in all cases involving medical staff until the investigation stage has been completed. A decision will then be made by the Case Manager on how to proceed. This procedure does not apply to personal conduct issues when at the hearing stage. The Trust's Disciplinary Policy & Procedure will apply to all medical staff against whom allegations of personal misconduct have been made. If, however, during the course of an investigation into allegations of personal misconduct, professional issues are uncovered, the matter should be dealt with under this procedure".

58. The "Purpose" of the policy is described at paragraph 2.1-2.2:

> "The aim of this policy is to ensure that all conduct, performance and health matters are recorded and dealt with in accordance with the framework set out in 'Maintaining High Professional Standards in the Modern NHS'
>
> This document is designed to inform all staff of the Trust's policy and procedures, and their rights and responsibilities in relation to such matters".

59. Appendix A to E27 is headed "Procedure for Handling Concerns about Conduct, Performance and Health of Medical and Dental Staff". Section 1 is headed "Action When a Concern Arises". At paragraph 1.1, it is stated that:

> "The management of performance is a continuous process which is intended to identify problems. Numerous ways now exist in which concerns about a practitioner's performance can be identified; through which remedial and supportive action can be

> quickly taken before problems become serious or patients harmed; and which need not necessarily require formal investigation or the resort to disciplinary procedures".

60. At paragraph 1.6, it is stated that:

> "Any potentially serious concerns, i.e. those which have or may adversely affect patient care, must be registered with the Chief Executive and he or she must ensure that a **Case Manager** is appointed. The Chairman of the Board must designate a non-executive member "Designated Board Member" to monitor the case during the investigation process and ensure that momentum is maintained. From this point he/she will receive reports, review any continued exclusion and/or restriction from work, consider any representations from the practitioner about his/her exclusion and/or restriction, and consider any representations about the investigation. All concerns should be investigated quickly and appropriately. A clear audit route must be established for initiating and tracking progress of the investigation, its costs and resulting action. However the issue is raised, the **Medical Director** will need to work with the Director of Human Resources and OD and NCAS to decide the appropriate course of action in each case. The **Medical Director** will act as the **Case Manager** in cases involving Clinical Leaders i.e. Clinical Directors and Service Group Leads and consultants and may delegate this role to a senior manager to oversee the case on his or her behalf in other cases. The **Medical Director** is responsible for appointing a **Case Investigator**".

(highlighting in the original).

61. Paragraph 1.7 provides for the Trust urgently to consider whether it is necessary to place temporary restrictions on the practitioner's practice when serious concerns are raised. The procedure for this is dealt with at section 2 of the Appendix. Paragraph 1.9 provides that the "first task of the Case Manager is to identify the nature of the problem or concern and to assess the seriousness of the issue on the information available and the likelihood that it can be resolved without resort to formal disciplinary procedures". This should be taken in consultation with "the Director of Human Resources and OD, the Medical Director and NCAS [now PPA]".

62. Under the heading "The Investigation", paragraph 1.13 provides that:

> "Where it is decided that a more formal route needs to be followed (perhaps leading to conduct or capability proceedings) the Medical Director must, after discussion between the Chief Executive and Director of Human Resources and OD, appoint an appropriately experienced or trained person as Case Investigator. The seniority of the Case Investigator will differ depending on the grade of practitioner involved in the allegation. Several clinical managers should be appropriately trained, to enable them to carry out this role when required".

The role of the Case Investigator is then described. At paragraph 1.18 it is provided that:

> "The Case Investigator has 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".

63. The Case Investigator is required to submit a report to the Case Manager. At paragraph 1.20 it is stated that:

> "The report of the investigation should give the Case Manager sufficient information to make a decision whether:
>
> • There are concerns about the practitioner's performance that should be further explored by NCAS; (see 1.21 below)
>
> • Restrictions on practice or exclusion from work should be considered; (see Section 2)
>
> • There is a case of misconduct that should be put to a conduct panel; (see Section 3)
>
> • There are intractable problems and the matter should be put before a capability panel; (see Section 4)
>
> • There are concerns about the practitioner's health that should be considered by the Trust's occupational health service; (see Section 5)
>
> • There are serious concerns that should be referred to the GMC or GDC;
>
> • No further action is needed.
>
> The Case Manager should decide what further action is necessary, taking into account the findings of the report and the advice of NCAS".

64. Section 2 of Appendix A is concerned with "Restriction of Practice & Exclusion from Work". For exclusions (a term which replaces, but is synonymous for these purposes with, the word "suspension"), the Trust Chief Executive "has overall responsibility" for managing the procedures and for ensuring that cases are properly managed. Paragraph 2.12 provides that "The decision to exclude a practitioner must be taken only by persons nominated under paragraph 2.14". Paragraph 2.14 provides:

> "The Medical Director will act as the Case Manager in the case of consultant staff, or delegate this role to a senior manager to oversee the case, and appoint a Case Investigator to explore and

> report on the circumstances that have led to the need to exclude the staff member. The investigating officer will provide factual information to assist the Case Manager in reviewing the need for exclusion and making progress reports to the Chief Executive and Designated Board Member".

65. Section 3 of Appendix A is concerned with "Conduct and Disciplinary Matters". This provides at paragraph 3.1 that "Misconduct matters for practitioners, as for all other staff groups, are dealt with under the Trust's Disciplinary Procedure". The hearing of cases involving issues of professional conduct is said at paragraph 3.2 to proceed to a hearing under the employer's conduct procedures at which one panel member must, in case of a doctor, be medically qualified. The Trust's document E5 – Disciplinary Policy – sets out the formal stages, including a disciplinary hearing, once "an investigation has been undertaken in accordance with the Investigation policy and the Case Manager has subsequently determined that there is a case for the employee to answer at a disciplinary hearing" (see paragraph 1.4).

66. Section 4 of Appendix A is concerned with "Issues of Capability". At paragraph 4.12, the role of the Case Manager is addressed. They must, among other things, "consider with the Medical Director and Director of Human Resources and OD whether the issues of capability can be resolved through local action (such as retraining, counselling, performance review)." Section 4 includes the process for a "capability hearing", and the range of decisions that the capability panel can reach, which include termination of the employee's contract.

The legal framework

(a) What are the contractual terms?

67. There was no real dispute between the parties as to the relevant law. The general principles of contractual interpretation were those set out by Lord Neuberger in Arnold v Britton [2015] AC 1619 at [15]:

> "When interpreting a written contract, the Court is concerned to identify the intention of the parties by reference to what a reasonable person having all the background knowledge which would have been available to the parties would have understood them to be using the language in the contract to mean . . . And it does so by focussing on the meaning of the relevant words . . . in their documentary, factual and commercial context. That meaning has to be assessed in the light of (i) the natural and ordinary meaning of the clause, (ii) any other relevant provisions of the lease, (iii) the overall purpose of the clause and the lease, (iv) the facts and circumstances known or assumed by the parties at the time that the document was executed, and (v) commercial common sense, but (vi) disregarding subjective evidence of the parties' intentions".

68. With respect to incorporation from a document external to the contract of employment itself, this can be done expressly (where the document is specifically referred to in the contract of employment) or impliedly. If the external document is incorporated, then it

is well accepted that the Court must determine whether any particular provision is "apt" to be a term of the contract: see Alexander v. Standard Telephones & Cables Ltd (No.2) [1991] IRLR 286 at [31].

69. In determining whether a provision is apt to be a term of the contract, in Hussain v Surrey & Sussex Healthcare NHS Trust [2011] EWHC 1670 at paras 168, 169, Andrew Smith J helpfully set out a number of the relevant indicia in the context of analogous provisions (a document entitled "Practitioners Disciplinary Procedure", which was a locally negotiated procedure for handling concerns about conduct and capability), as follows:

> "168. There is no single test as to whether an employer and employee intended to agree that provisions of an agreement such as the Practitioners Disciplinary Procedure should be contractual between them (rather than advisory or hortatory or an expression of aspiration), and if so which provisions. The indicia that a provision is to be taken to have contractual status which are, I think, of some relevance to this case include these:
>
> i) The importance of the provision to the contractual working relationship between the employer and the employee and its relationship to the contractual arrangements between them: as I understand it, it is common ground in this case that, because parts of the Practitioners Disciplinary Procedure are contractual, in some circumstances the Trust might exclude Dr Hussain or bring disciplinary proceedings for misconduct against her. The implication of this, as it seems to me, is that provisions important to implementing the agreement about exclusion and about conduct hearings are also apt to be contractual: the more important the provision to the structure of the procedures, the more likely it is that the parties intended it to be contractual.
>
> As Auld LJ said in *Keeley v Fosroc International Ltd*, [2006] IRLR 961 (which concerned whether provisions relating to enhanced redundancy payments in a Staff Handbook were enforceable as part of individual contracts of employment),
>
> "Highly relevant in any consideration, contextual or otherwise, of an "incorporated" provision in an employment contract, is the importance of the provision to the over-all bargain, here, the employee's remuneration package – what he undertook to work for. A provision of that sort, even if couched in terms of information or explanation, or expressed in discretionary terms, may still be apt for construction as a terms of his contract … ." (at para 34).
>
> ii) The level of detail prescribed by the provision: as Penry-Davey J said in *Kulkarni v Milton Keynes Hospital NHS Trust*, [2008] IRLR 949 at para 25, the courts should not "become involved in the micro-management of conduct hearings", and the parties to the contract of employment are not to be taken to have

> intended that they should be. (In the Court of Appeal in *Kulkarni*, (loc cit) at para 22, Smith LJ endorsed this observation of Penry-Davis J.)
>
> iii) The certainty of what the provision requires: as Swift J observed (in *Hameed* (loc cit) at para 68), if a provision is vague or discursive, it is the less apt to have contractual status.
>
> iv) The context of the provision: a provision included amongst other provisions that are contractual is itself more likely to have been intended to have contractual status than one included among other provisions which provide guidance or are otherwise not apt to be contractual.
>
> v) Whether the provision is workable, or would be if it were taken to have contractual status; the parties are not to be taken to have intended to introduce into their contract of employment terms which, if enforced, not be workable or make business sense: see *Malone v British Airways*, [2010] EWCA Civ 1225 at para 62.
>
> 169. This is not, of course, an exhaustive list of considerations which might bear upon whether a provision in a collective agreement is apt to have contractual status. In particular, the wording of the provision is also of significance. I observe that in the Practitioners Disciplinary Procedure some provisions are expressed in terms of what "must" be done and others in terms of what "should" be done. I have already (at paragraph 135 above) commented upon the significance of this in the specific context of paragraph 1.15. I am otherwise unable to discern from the procedure as a whole any pattern to this varying terminology, and generally I do not regard the use of "should" rather than "must" as indicative that a provision in it is not intended to be contractual or is not apt to have contractual status".

The analysis in Hussain was said by McCombe LJ in Sparks v. Department for Transport [2016] ICR 695 at [17], to be among "the most helpful" authorities in resolving the issues that had to be determined in the case before them.

70. The contract between a doctor and their employing Trust will also include the implied term that "the employer may not without reasonable and proper cause conduct itself in a manner calculated and likely to destroy or seriously damage the relationship of confidence between employer and employee and trust between them": see Malik v Bank of Credit and Commerce International [1998] AC 20, p45F-G (endorsing Browne-Wilkinson J's dictum in Woods v. W. M. Car Services (Peterborough) Ltd. [1981] I.C.R. 666, 670). The caveat of "reasonable and proper cause" entails a high threshold: see Stevens v University of Birmingham [2017] ICR 96 at [99].

71. In Chakrabarty v Ipswich Hospital NHS Trust [2014] EWHC 2735, Simler J did not accept that a general obligation to act fairly was implied into a contract of employment. Simler J observed at [114] that "where the authorities contemplate questions of fairness,

they do so in the context of the implied term of trust and confidence, or on a narrower basis by reference to an implied term that disciplinary processes will be conducted fairly, without unjustified delay." See also, Chhabra v West London Mental Health NHS Trust [2014] ICR 194, where Lord Hodge found that the doctor in that case had, in the context of a disciplinary process, "an implied contractual right to a fair process".

(b) Prohibition against "sidestepping"

72. In a number of cases involving doctors, the Court has focused on the importance of following the proper procedures where capability or conduct is concerned, and has cautioned against employers who have sought to "side-step" those procedures by labelling the matters of concern as "some other substantial reason".

73. "Some other substantial reason" is one of the potentially fair reasons for dismissal under the statutory unfair dismissal regime. Section 98(1) of the Employment Rights Act 1996 provides that:

> "In determining for the purposes of this Part whether the dismissal of an employee is fair or unfair, it is for the employer to show—
>
> (a) the reason (or, if more than one, the principal reason) for the dismissal, and
>
> (b) that it is either a reason falling within subsection (2) or *some other substantial reason of a kind such as to justify the dismissal* of an employee holding the position which the employee held".

(emphasis added). A reason falls within subsection (2) if it:

> "(a) relates to the capability or qualifications of the employee for performing work of the kind which he was employed by the employer to do,
>
> (b) relates to the conduct of the employee,
>
> (c) is that the employee was redundant, or
>
> (d) is that the employee could not continue to work in the position which he held without contravention (either on his part or on that of his employer) of a duty or restriction imposed by or under an enactment".

74. In Kerslake v North West London Hospitals NHS Trust, [2012] EWHC 1999 (QB), His Honour Judge Curran (sitting as a Judge of the High Court) held at [182] that the Trust in that case was not permitted to dismiss a doctor under the guise of 'some other substantial reason' if the real reason for dismissal was capability or misconduct. This was referred to as "sidestepping" and would be an impermissible circumvention of the procedures contained in MHPS.

75. HHJ Curran cited as authority for this proposition the judgment of Holroyd J, determining an application for an interim injunction in Lauffer v Barking, Havering and

Redbridge University Hospitals NHS Trust [2009] EWHC 2360 (QB). In Lauffer, Holroyde J had held at [39] that the contractual provision relating to 'some other substantial reason' was a residual category of cases where there was no misconduct or capability issue, "for example, a clash of personalities". Holroyd J accepted the submission that "the MHPS inspired scheme cannot, as he puts it, be sidestepped by relabelling".

(c) The application of MHPS

76. There have been a number of cases in which provisions of MHPS have been considered by the Courts, and the approach to interpreting those provisions has been discussed. In Chakrabarty, Simler J observed at [116] that:

> "An important part of the relevant background here is the way in which the MHPS framework was agreed. Its essential character is that of a collective agreement negotiated by officials from the Department of Health and representatives from affected bodies including the NCAS's predecessor body. Accordingly it is all the more important that it should not be construed as a statute but rather, a practical, purposive interpretation is appropriate having regard to the statutory functions of the NCAS and the way in which the NCAS performs those functions. Its discursive terms ought not to be read in a way that would introduce unhelpful inflexibility or make its application unduly restrictive. Mr Sutton also contends and I accept, the MHPS framework is a procedure designed to govern the resolution of concerns about a practitioner's conduct or capability arising in the context of the employment relationship. A proper interpretation of MHPS can therefore be expected to reflect the hierarchical character of that relationship where the ultimate decision-making power and responsibility is vested in the employer who is entitled to exercise a contractual right through a disciplinary or capability process to terminate the employment".

77. In Burn v Alder Hey NHS Foundation Trust, [2021] EWHC 1674 (QB), Thornton J observed at [11(d)] that:

> "The Court should work on the basis that the parties to MHPS considered that it struck a fair balance between the important, potentially competing interests. These are: a public interest in the effective and efficient management of the conduct, capability and performance of medical professionals; and the interests of the practitioner for whom there is potentially a great deal at stake for the practitioner and for whom the procedure may provide them with an opportunity for vindication or, at least, that the faithful application of the procedure would ensure fairness (Smo v Hywel Dda University Health Board [2020] EWHC 727 (QB))".

The parties' submissions

(a) Submissions on behalf of Dr MN

78. Dr MN, represented before me by Mark Sutton KC and Nicola Newbegin, submits that the policy set out in E27 is incorporated into his contract of employment, and that it is a term of his contract as a Consultant that the Medical Director (in this case Mr Z, the Trust's Chief Medical Officer) must serve as the 'Case Manager' and cannot delegate that role to anyone else. In other words, the relevant parts of paragraph 1.6 of E27 are apt for incorporation.

79. Mr Sutton KC contended that paragraph 1.6 was triggered in this case as "potentially serious concerns" had been raised about Dr MN's judgment and conduct. Mr Sutton KC submitted that for paragraph 1.6 to be engaged it was not necessary that the "potentially serious concerns" were those which "have or may adversely affect patient care". Mr Sutton KC suggested that there was an error in the text of E27, where it used the abbreviation 'i.e.' in the first sentence of paragraph 1.6, to qualify the meaning of "Any potentially serious concerns" which "must be registered with the Chief Executive" who "must ensure that a Case Manager is appointed". Mr Sutton KC argued that the abbreviation that must have been intended was 'e.g.': that the impact on patient care was merely illustrative of "potentially serious concerns" which would trigger registration with the Chief Executive and appointment of a Case Manager. Mr Sutton KC contended that that is the proper way to read the text so as to conform with MHPS which was concerned with "All serious concerns" and not just those that affected patient care. It was also consistent with the purpose of the policy at E27, which is intended to deal with "all conduct, performance and health" matters. This could include concerns relating to probity, insulting colleagues, sexual misbehaviour towards colleagues in the workplace, which would all be examples of bad behaviour without affecting patient care. In any event, Mr Sutton KC submitted that the concerns that were raised about Dr MN did affect, or may affect, patient care, and this was accepted by the Trust's own witnesses when giving evidence at trial.

80. Mr Sutton KC contended that the requirement that the Medical Director should be the Case Manager for Consultants like Dr MN was apt for incorporation for a number of reasons:

    (i) The requirement that the Medical Director acts as Case Manager is one that provides significant protection and assurance for a Consultant like Dr MN: the decision-making made by the Case Manager may have significant ramifications for the Consultant's employment and career progression; the Medical Director is the most senior clinician in the organisation and will be able to assess issues through the lens of a senior clinician: the issues investigated in relation to a doctor are highly likely to raise issues of clinical conduct or capability.

    (ii) The provision is clear; it is not vague or discursive. The language is expressed in mandatory terms, and is grouped together with other mandatory obligations in the same provision.

    (iii) The provision is workable, and had the Trust wished to have flexibility as to whom to appoint as Case Manager in the case of Consultants, it could have

sought to amend the policy locally via the Joint Local Negotiating Committee as had been done by Morecambe Bay NHS Foundation Trust. At Morecambe Bay, the policy that had been agreed was that the Case Manager for a concern related to a Consultant could be "the Medical Director/Deputy Director or Senior Consultant (acting as Medical Director)";

(iv) In circumstances where it is impossible for the Medical Director to perform their function, a deputy Medical Director or other senior clinical leader would need to step into their role. Support for this is provided by the provision in MHPS for circumstances where there is no Medical Director.

(v) The provision mirrors the national policy (MHPS).

(vi) The evidence from Mr Wilkinson and from the other Trusts is not decisive, as there is no evidence as to whether there have been local agreements derogating from MHPS to explain why investigations involving Consultants were being conducted by persons other than the Medical Director.

81. Mr Sutton KC submitted that the Trust had clearly breached that express contractual obligation by appointing Ms Y to serve as Case Manager rather than Mr Z, and the purported delegation from Mr Z to Ms Y was a nullity: this is not permitted by the contract of employment.

82. Alternatively, Mr Sutton KC referred to the fact that the Trust had stated, in their letter of 15 March 2024, that they "intend to apply and adhere to [MHPS] as part of a general obligation, to which the Trust commits, to treat [Dr MN] fairly". In doing so, Mr Sutton KC submitted that the Trust must be taken to be applying the provision that the Case Manager should be the Medical Director. To decide otherwise would allow the Trust to pick and choose which procedural protections they wish to apply. This offended against the duty of fairness, which requires the Trust to adhere to all procedures, including that the Medical Director will be the Case Manager. To decide otherwise would also breach the implied term of trust and confidence, and there is no "reasonable and proper cause" to satisfy the caveat to that term.

83. In any event, Mr Sutton KC submitted that, as a result of her involvement in giving evidence to the Thirlwall Inquiry, Ms Y's insistence on continuing in the role of Case Manager was and would be a breach of the implied terms of the employment contract. The witness statement and exhibits provided to the Thirlwall Inquiry demonstrate that Ms Y cannot be independent and fair: an implicit requirement of the E27 policy. Ms Y referred in her evidence to the Thirlwall Inquiry to matters that are potentially matters that the internal investigation, and any future hearing panel, may wish to test. Ms Y also made unnecessary and critical assertions about Dr MN and his legal representatives, which calls into question her ability to occupy a position of detachment and objectivity. Ms Y also sought to control who the Thirlwall Inquiry could speak to (namely, BK) and the information that the Thirlwall Inquiry received, which raised further concerns about her involvement in the role of Case Manager.

84. With respect to relief on the Case Manager point, Mr Sutton KC submitted that as Mr Gorton KC had made it clear, on behalf of the Trust, that the Trust will comply with this Court's ruling on the matter of who should serve as Case Manager at the conclusion

of the investigation, there was no need for injunctive relief; Dr MN was content for declaratory relief to be ordered.

85. Mr Sutton KC also argued that on the basis of the alleged concerns that are the subject of the investigation, it would not be open to the Case Manager to attempt to side-step MHPS/E27 by seeking to dismiss Dr MN, or embark on a process that could lead to his dismissal, for breach of the duty of trust and confidence by labelling the matters subject to the investigation as 'some other substantial reason'. This matter was sufficiently pleaded in the Particulars of Claim. Moreover, framing matters as reputational issues for the Trust would be irrational and in breach of the Trust's duty of trust and confidence towards Dr MN. The concerns that have been set out by the Trust for investigation were those of Dr MN's professional conduct and/or capability. Fairness demands that the contractually agreed processes are followed, and the principle of fairness would be contravened if Dr MN was made to go to a hearing relating to trust and confidence where (a) there has been no investigation of these matters, (b) Dr MN will not have been given the chance to "clear his name", and (c) the only outcome if a breach is found is that of dismissal. Mr Sutton KC accepted, however, that it would be possible for the Trust to seek to investigate reputational matters, albeit he suggested that this would be difficult, but that investigation had not been carried out so far. If the Trust was to investigate these matters, that would require a clear articulation of fresh concerns, as reputation was not mentioned in the terms of reference provided to *Verita* or subsequently to Mr A.

(b) Submissions on behalf of the Trust

86. Simon Gorton KC and Jack Mitchell appeared on behalf of the Trust. They submitted that the Trust accepted that E27 was incorporated into Dr MN's contract of employment. They also accepted that certain provisions – such as the right of the Trust to exclude a doctor whilst an investigation was in progress – were apt for incorporation as terms of Dr MN's contract. That did not apply, however, to paragraph 1.6.

87. It was submitted that paragraph 1.6 was not apt to be given contractual effect, and should be treated as guidance instead.

(i) The provision does not regulate the employer/employee relationship, but is an internal facing matter relating to the conduct of the Trust.

(ii) It would not be a workable provision if Dr MN's suggested interpretation was found to be contractual: it would require the Medical Director to determine and act as a Case Manager in matters relating to their own conduct and or capability; if a Medical Director was sick, no Case Management could be undertaken at all; if (as had actually occurred in this case with respect to Mr Z) a Medical Director is a witness to the matter being investigated, the Medical Director would be required to act in direct conflict of interest and that would offend basic principles of natural justice or fairness.

(iii) There is evidence from Mr Wilkinson of PPA that delegation is a universal national practice; there was also evidence of delegation from the other Trusts in the locality.

(iv) The interpretation suggested by Mr Sutton KC would be inconsistent, and in conflict, with other parts of E27 (eg. paragraph 2.14 – which permits the Medical Director to delegate the Case Manager role for the purposes of exclusion; and paragraph 4.12 – which presupposes in the context of investigations into 'capability' that the Medical Director will not be the Case Manager as it states that the "Case Manager will need to consider with the Medical Director" among others whether local action can resolve matters).

(v) The language used at the relevant part of paragraph 1.6 -- 'will' -- is manifestly different to 'must', language which is used elsewhere in that paragraph. It was not appropriate to interpret the two terms to mean the same thing.

88. It was also submitted that, whether or not paragraph 1.6 is apt for incorporation, the precondition to its application – that there were "potentially serious concerns, i.e. those which have or may adversely affect patient care" – was not satisfied here. The concerns raised with the Trust about Dr MN, and which were being investigated, did not affect patient care. Whether or not Dr MN had knowledge about Lucy Letby that impacted on his seeking to arrange her visits to the Hospital was not a matter of patient care or medical skill. It was a matter of judgment. The allegation that Dr MN shared information about Baby N when he was actually an employee of a different organisation was not a matter that concerned clinical treatment, or the care provided to a patient. Indeed, even if Baby N had been a patient of the Trust this would not breach patient care.

89. Further, Mr Gorton KC submitted that the Trust disputes that Ms Y has acted in any way as Case Manager that breaches the contract of employment with the effect that she should be prohibited from taking the relevant decision at the end of the investigation. Ms Y was expressly requested by the Thirlwall Inquiry to provide information, and the material she provided was not based on her own evidence or recollections. In any event, the Trust had acted with reasonable and proper cause – a fundamental qualification to the trust and confidence test – and its conduct is not so severe as to justify a finding of breach.

90. With respect to relief on the Case Manager point, Mr Gorton KC informed the Court that if it was decided that the Medical Director should be the Case Manager then there would not be any need for injunctive relief to be granted. The Trust would follow the Court's judgment, as a sensible public body. Mr Gorton KC also contended that declaratory relief would also not be required.

91. Mr Gorton KC also submitted that the Trust should not be prohibited from concluding that the matter that needed to be addressed with Dr MN at the end of the investigation was one of "trust and confidence". Trust and confidence was properly categorised as 'some other substantial reason', and so falls outwith MHPS/E27. Mr Gorton KC pointed out that there were various instances where 'some other substantial reason' had been made out as a potentially fair reason for dismissal in the statutory employment law context; and the category was not limited to where there had been falling out with colleagues or third-party pressure to dismiss an employee. In the instant case, the Trust had been signalling for some time that the matter of reputational damage to the Trust as a result of Dr MN's actions may, potentially, justify consideration being given to a trust and confidence dismissal. This was reflected in the Trust's Amended Defence where references to the Trust in the media had been set out, and it was specifically

pleaded that by the autumn of 2023 the Trust was concerned with issues arising from "Reputational risk management, specifically and most importantly any potential concerns in the eyes of its patients, families and the public arising from the fact of the visits".

92. Mr Gorton KC contended that the submission about "side-stepping" had not been pleaded by Dr MN, and was not therefore an issue that the Court had to address. Furthermore, the matter was premature in any event as the investigation process was still at an early stage. Nevertheless, for practical reasons, the Trust was content if the Court did wish to express its views on this matter so as to assist the parties going forward.

Discussion

Issues 1-3: Was the Medical Director required to be the Case Manager for this investigation?

93. I consider that issues 1-3 can be considered together. The compound question to consider is whether the Medical Director (here the Chief Medical Officer) is required to be the Case Manager for this investigation. In short, my judgment is that it is a term of Dr MN's contract of employment that the Case Manager should be the Medical Director for the matters that are the subject of the present investigation; and that the Trust must ensure that Mr Z carries out that role once the investigation has been completed unless one of the exceptional circumstances that justifies departure from that requirement applies. I reach this conclusion for a number of reasons.

94. First, E27 is incorporated into Dr MN's contract of employment. It is referred to (via the reference to the Trust's procedures that are consistent with MHPS) in Dr MN's contract of employment. This is accepted by the Trust.

95. Second, the investigation undertaken by the Trust falls within the scope of paragraph 1.6. According to that paragraph, "Any potentially serious concerns, i.e. those which have or may adversely affect patient care, must be registered with the Chief Executive and he or she must ensure that a Case Manager is appointed." On its face, therefore, the nature of the concerns that lead to the appointment of a Case Manager, are those which are "potentially serious", which – by use of the abbreviations "i.e" (*Id est* – meaning "that is") – are "those which have or may adversely affect patient care".

96. This threshold definition appears to be deliberate, as at least part of that wording is also reflected in the Quick Reference Guide to E27, which states that "Any potentially serious concerns which may adversely affect patient care must be registered with the Chief Executive and a Case Manager appointed." In reality, this definition will capture all of the concerns set out at paragraph 1.6, as if a concern *has* already affected patient care then it would also be a concern that "may" affect patient care.

97. The language at paragraph 1.6 seems to be taken from paragraph 3 of the Introduction to the MHPS, which states that: "All NHS bodies must have procedures for handling serious concerns about an individual's conduct and capability**", and the key provided by the double star ** is said to be "A serious concern about capability will arise where the practitioner's actions have or may adversely affect patient care".

98. Mr Sutton KC contended that the definition of "serious concerns" in MHPS, which should inform the construction of paragraph 1.6, is not limited to concerns where the practitioner's actions "have or may adversely affect patient care", as MHPS also refers to the more general "serious concerns about an individual's conduct", a term is not defined in MHPS and is not limited to the impact on patient care. I disagree. E27 has, as I have said, deliberately used the threshold of concerns (whether or conduct or capability) "which have or may adversely affect patient care". Either that reflects the understanding of the Local Negotiating Body at the Trust of what the MHPS calls for, or it is a refinement of what the MHPS calls for in the context of the Trust which, as a Foundation Trust is not obliged to adhere to the letter of the MHPS.

99. That approach by the Trust cannot be said to be an unreasonable or absurd one which might justify a reading of paragraph 1.6 as if the abbreviation "i.e." was a mistake, and that the abbreviation that the parties must have intended was "e.g.". It is not unreasonable or absurd for the Trust to use the threshold of impacting patient safety for applying the procedures set out in E27 given the importance to the Trust of safeguarding patient safety. Furthermore, the abbreviation suggested by Mr Sutton KC of "e.g." (meaning, for example) is not particularly helpful to identify what the definition of a "potentially serious concern" is.

100. In any event, on the facts of this case, this does not actually matter. The allegations against Dr MN set out in the terms of reference were of matters that "may adversely affect patient care". This was accepted by the Trust's witnesses at the trial.

101. Furthermore, I consider that the reference to "patient care" within E27 is not confined to patients of the Hospital, but could apply to patients elsewhere. Thus, even if it was accepted at the outset that Lucy Letby did not have unsupervised access to patients of the Hospital, the learning that she gained might have impacted on how she treated patients or may have treated patients elsewhere.

102. As for the allegation relating to patient confidentiality of Baby N: this patient was initially a patient at COCH and subsequently at the Hospital. A breach of patient confidentiality might impact on how that patient is treated and cared for. Furthermore, a breach by a medical practitioner of patient confidentiality on one occasion may call into question their approach to patient confidentiality – which could impact on patient care depending on the nature of the breach – on another occasion.

103. Third, the meaning of the relevant part of paragraph 1.6 is that where a relevant investigation is being conducted into a medical practitioner in the role of Consultant, as Dr MN is, the Medical Director <u>has to be</u> the Case Manager and cannot delegate that role.

104. That meaning is the natural meaning of the language used at paragraph 1.6. The language of "The Medical Director will act as the Case Manager" is the language of what is going to happen. This is reinforced by the subsequent wording with respect to delegation. A contrast is made in the text between what is going to happen where the cases involve Clinical Leaders (which includes consultants) and "other cases". In the latter situation, the language of the text is that the role of Case Manager "may" be delegated. That is not the situation for the cases involving Clinical Leaders. Thus, the language reads: "The Medical Director *will act* as the Case Manager in cases involving Clinical Leaders i.e. Clinical Directors and Service Group Leads and consultants and

*may delegate* this role to a senior manager to oversee the case on his or her behalf in other cases" (emphasis added).

105. In this context, there is no material difference in meaning in this context between a statement that the Medical Director "will act" as Case Manager and the wording "must act", although the latter wording would have been more emphatic. The fact that there are references elsewhere in the particular paragraph to the terms "must" (e.g. "Any potentially serious concerns . . . *must* be registered with the Chief Executive Officer and he or she *must* ensure that a Case Manager is appointed" (emphasis added) does not mean that the later reference to "will act" involves a different obligation.

106. The obligation on the Trust that the Medical Director "will act" as Case Manager (and cannot delegate that role) in respect of investigations into Clinical Leaders is, in my judgment, *apt* for incorporation. Analysing the matter in line with the indicia helpfully referred to by Andrew Smith J in Hussain, I consider that:

i) The provision as to who will perform the role of Case Manager for investigations involving Clinical Leaders (including Consultants) is of real importance to the contractual working relationship between the employer and the employee and the "overall bargain" that they have made. Clinical Leaders are senior medical personnel employed by the Trust. Given their status and role within the organisation and the significance to them and their career within the medical profession of an investigation, it would be expected that key decisions, including determining what should happen once the investigation has been completed, should be taken by a very senior person within the Trust, and there is every reason for it to be taken by a person in a more senior role than the person being investigated. Further, given that the scope of investigation under paragraph 1.6 will ordinarily involve matters of conduct and performance as a medical professional, it would also be expected that the key decision should be taken by a person with medical knowledge and experience.

ii) The provision as to who will serve as Case Manager is a matter of detail, in that it prescribes a key player in the investigation process. Nevertheless, it does not involve the kind of micro-management of conduct hearings themselves – and, in particular, what evidential material could be used at a disciplinary hearing -- that was decried by Penry-Davey J in Kulkarni v Milton Keynes Hospital NHS Trust, [2008] IRLR 949 at para 25, an observation approved by Smith LJ in the Court of Appeal at [2010] ICR 101 at [22].

iii) The provision is certain. It is clear what the provision requires.

iv) The provision is included amongst other provisions that are contractual. Indeed, the Trust accepts that the provisions relating to exclusion of a practitioner are apt for incorporation. These appear in the next section of E27.

v) The provision is workable, or would be if it were taken to have contractual status. It is not a term which does not make business sense. It is very far from the term that was contained in the collective agreement being discussed by the Court of Appeal in Malone v British Airways, [2011] ICR 125 at [62] (cited in Hussain). In Malone, the claimants were cabin crew who sought to argue that a term relating to crew complement levels was contractual. The Court of Appeal

> held at [62] that there would be "disastrous consequences" for the employer airline if the term was to be individually enforceable; as the term would enable an individual or small group of cabin crew members to bring a flight to a halt by refusing to work if the minimum crew complement was not available.

107. There will not be "disastrous consequences", or anything close, if the Medical Director had to serve as the Case Manager in cases involving Clinical Leaders. I accept that the role of Medical Director is a substantial one, with a wide range of responsibilities and duties. It is also the case that the function of being a Case Manager for an investigation into a Clinical Leader will take up some time and thereby add to what is already likely to be a heavy workload for the post-holder. Nevertheless, the Case Manager role within E27 is essentially one of taking key decisions at various points within the investigation process; it does not involve day-to-day work such as that which might be required of the Case Investigator. Furthermore, although the preferred interpretation of paragraph 1.6 is that the Medical Director cannot delegate the function of Case Manager for investigations involving Clinical Leaders, there is nothing to prevent the Medical Director from receiving the assistance and advice of other personnel in carrying out the role of Case Manager, as long as the Medical Director makes the decisions and carries out the specific actions required of the Case Manager. In addition, the non-delegable obligation of being Case Manager applies only to investigations of Clinical Leaders and not to the far more numerous junior medical staff. If the relevant provision of E27 had stated that the Medical Director 'will act' as Case Manager in every case, then the workability of that being a contractual obligation would be more questionable.

108. The evidence from Mr Wilkinson, on behalf of the PPA, was not that the Medical Director could not perform the role of Case Manager. To the contrary, he referred to the Medical Director/Chief Medical Director serving as Case Manager in 210 (that is, 43%) of the 489 cases where a Case Manager had been appointed for an investigation involving Consultants. Moreover, there was always the possibility of seeking to agree with the Local Negotiating Committee an amendment to E27 if the situation was becoming unworkable for the Medical Director to carry out the Case Manager function.

109. I accept that there will be circumstances in which it would not be appropriate, or possible, for the Medical Director to serve as the Case Manager in a particular case. As a matter of fairness, the Medical Director ought not to serve as Case Manager if they had personal or direct knowledge of the key subject matter of the investigation, or because they are the partner, or a close relative of the Clinical Leader being investigated. There may also be circumstances of ill-health or other lengthy absence which would render it impossible for the Medical Director to carry out the function of Case Manager. Although these examples can easily be envisaged, they will, in all likelihood, only apply exceptionally, and do not mean that the obligation is unworkable *per se.*

110. These exceptions, or qualifications, to the requirement that the Medical Director has to carry out the function of Case Manager, will be implied into the employment contract. It would be obvious to the parties, satisfying the "officious bystander" test, that the Medical Director could not serve as the Case Manager where the Medical Director was unable to carry out the function due to ill health, or where they would, so as to satisfy principles of fairness, have to recuse themself.

111. A further reason for why the paragraph 1.6 reference to the Medical Director having to act as Case Manager is apt for incorporation is that the language used is suitable for a contractual obligation. Indeed, if the language of paragraph 1.6 had been set out directly in the written contract of employment, it would have been regarded as giving rise to a contractual requirement.

112. Furthermore, of some significance is that the same wording appears in MHPS, reflecting the importance of the requirement that the Medical Director should serve as the Case Manager for "cases involving clinical directors and consultants and may delegate this role to a senior manager to oversee the case on his or her behalf in other cases". This is something which has been agreed at the national level for the NHS as a whole, and is binding on NHS Trusts and recommended for Foundation Trusts.

113. I acknowledge that there are some areas of the text of E27 that might sit somewhat uncomfortably with this interpretation: Mr Gorton KC referred to paragraphs 2.14 and 4.12. Nevertheless, it seems to me that these other provisions of E27 can be explained without undermining the construction put forward by Dr MN.

114. With respect to paragraph 2.14, this is dealing with the specific situation relating to the exclusion of a Consultant and contemplates the Medical Director delegating the role of Case Manager to a senior manager to oversee the case. That is a very specific set of circumstances which does not apply in all cases of an investigation into a Consultant. Those circumstances may require intensive and time sensitive input by the Case Manager or their delegate, as the provision goes on to say that the Case Manager will review "the need for exclusion and making progress reports" to the Chief Executive and Designated Board Member. In these circumstances, it is not surprising therefore that the locally agreed policy expressly permits the Case Manager to delegate their responsibility. The fact that there is such an exception does not justify a different reading of paragraph 1.6 and the identity of the person who carries out the role of Case Manager ordinarily.

115. With respect to paragraph 4.12, this is dealing with the specific issue of capability and whilst it may seem redundant to say that "The Case Manager will need to consider with the Medical Director" if they are the same person, that will not always be the case. The Case Manager will not be the Medical Director if, for staff other than Clinical Leads, the role of Case Manager has been delegated. This could have been made clearer in the text, but the fact that it is not made clearer does not undermine the language of paragraph 1.6 which is abundantly clear. Moreover, it is notable that the Medical Director is not the only person with whom the Case Manager must consider whether issues of capability can be resolved through local action: they must also consider those issues with the Director of Human Resources and OD. In other words, the entire procedure for consideration is not, even where the Case Manager is the Medical Director, with oneself.

116. My conclusion, therefore, is that the Medical Director is required to be the Case Manager and was not, according to the terms of paragraph 1.6, permitted to delegate that role. Accordingly, the purported delegation was in breach of Dr MN's contract of employment.

117. Whether or not Mr Z, as the Medical Director, must serve as the Case Manager once the investigation is complete will depend, in my judgment, on whether any of the

qualifications to the general rule that I have outlined at paragraphs 109-110 apply. At this stage, it is premature to make any findings as to whether or not any qualifications apply. What I can, say, however, is the mere fact that Mr Z may be interviewed as part of the investigation would not mean that he could not serve as the Case Manager once the investigation was complete. The Case Manager is not the ultimate decision-maker with respect to the Consultant's employment. The requirements of fairness for the Case Manager role are therefore less stringent than would apply to the ultimate decision-maker.

118. In my judgment, whether or not Mr Z can, in accordance with principles of fairness, perform the role of Case Manager at the conclusion of the investigation and determine next steps will depend on the outcome of the investigation and the materiality of anything that Mr Z had to say in his interview to the decision that would have to be taken on next steps.

119. Given that I have found that it was a contractual term that the Medical Director should (with the qualifications expressed at paragraphs 109-110) serve as the Case Manager for an investigation of a Consultant, the question of whether that same result arises pursuant to the duty of trust and confidence does not arise. As the matter was fully argued, however, I will deal with the matter briefly.

120. In my judgment, it would not have been a breach of the duty of trust and confidence for the Trust to state that it would be adhering to the procedures set out in MHPS, but make an exception for the identity of the Case Manager. On the assumption that the procedures set out in MHPS that relate to the identity of the Case Manager are not incorporated into the Consultant's contract of employment, there is no reason why the Trust could not decide to derogate from some of the procedures set out in MHPS even if others were followed. The touchstone for what the Trust could do is that of fairness: there is no reason, in principle, why it would have been unfair for the Trust to appoint someone other than the Chief Medical Officer as Case Manager for the investigation. That other person could have been a senior member of staff such as Ms Y.

Issue 4: whether appointing Ms Y as Case Manager or authorising her to continue as Case Manager is a breach of the implied terms of the employment contract

121. It is not strictly speaking necessary for me to consider this issue as it is premised on the Court finding against Dr MN on the contractual question that I have answered above. That is, if it is a breach of the express terms of the contract – incorporated from E27 – for Ms Y to serve as Case Manager, it does not add anything if her continuation in that role is a breach of the implied terms as a result of things that she has done. I will, however, address the question as it was argued in full before me.

122. I do not consider that the allegation of breach of the duty of trust and confidence as a result of Ms Y's conduct is made out. It is submitted by Mr Sutton KC that Ms Y's involvement with and evidence to the Thirlwall Inquiry demonstrates that she could not carry out the key function of Case Manager – to determine the next steps once the investigation was completed – in a detached and fair way. I disagree.

123. First, I do not consider what Ms Y has done so far demonstrates that she could not, let alone will not, take a decision once the investigation is complete in a detached and fair way. What Ms Y said to the Thirlwall Inquiry does not indicate bias or hostility towards

Dr MN; nor does it indicate that she has come to a firm view as to Dr MN's actions or omissions, or as to the option that has to be pursued in his case, before the completion of the investigation. Ms Y may have taken umbrage at the various challenges to the investigation process, but this does not mean that she cannot keep an open mind about what option to take once the investigation has been complete. Similarly, the fact that Ms Y expressed a view to the Thirlwall Inquiry as to the necessity for them to seek evidence from BK does not mean that Ms Y cannot keep an open mind once the investigation has concluded.

124. Second, in any event, it is far too early in the investigation process for this to be considered. Fairness must be looked at in the round, and at the time that the key decision is taken. Merely because Ms Y may have indicated certain views at this stage does not mean that she will maintain these views once the investigation has been completed.

Issue 5: If the Investigation Report identifies concerns which relate to Dr MN's conduct and/or capability, is the Trust required to implement the procedures set out in the E27 Policy at Section 3 and/or Section 4 before taking action in relation to Dr MN's employment.

125. Once again this is not a matter that I am obliged to consider given that the investigation has a long way to go and it is not known what options might be presented by the investigator for consideration by the Case Manager. However, as I have heard full argument on the matter and as this may be of some assistance to the parties and possibly avoid the need to engage in litigation later on in the proceedings, I will consider the arguments made by the parties.

126. It is clear from the case law that the Trust will not be permitted to side-step the procedures set out in E27 by treating the matters complained of as being concerned with "trust and confidence", and therefore subject to a different process, when they ought to be treated as matters of conduct and/or capability. That would itself be a breach of the duty of trust and confidence that the Trust owes to Dr MN.

127. In the instant case, the Terms of Reference for the investigation concern matters that go to Dr MN's conduct and/or capability, even if the effect of these matters if proven would impact on, or affect, the trust and confidence that the Trust would have in Dr MN. The fact that there has been mention of reputational issues in correspondence from the Trust or its solicitors, and those matters have been referred to in the Amended Defence (paragraph 29.2 refers to "Reputational risk management") does not alter what is contained within the Terms of Reference. The Terms of Reference do not call for investigation into reputational issues.

128. Accordingly, based on the investigation so far, and the tramlines set by the Terms of Reference, it would not be open to the Trust to change course and subject Dr MN to a different process at the end of the investigation merely because the Trust wishes to label the matters being investigated as being related to trust and confidence. The matters being investigated are matters of conduct and/or capability, even if they impact on trust and confidence.

129. The matter would be different, however, if as part of the investigation the Trust explicitly stated, by amending the Terms of Reference, that it would be examining the impact that the arrangement by Dr MN of the observational visits by Lucy Letby had on the reputation of the Trust. Mr Sutton KC accepted, rightly in my judgment, that this

would be a matter of trust and confidence that would not also call into question Dr MN's conduct and/or capability. In statutory employment law terms, this would fall within the ambit of a 'some other substantial reason' for the dismissal: see e.g. Leach v Office of Communications [2012] ICR 1269, where it was held that the risk of reputational damage to an employer could justify a dismissal for 'some other substantial reason' of an employee who been accused of being a child sex offender and a continuing risk to children, albeit the accusation was not substantiated.

130. If the Trust did choose to alter the scope of the investigation to include reputational issues, then it would be open to the Trust (if the evidentiary threshold was made out) to take Dr MN through a procedure in which the reputation issue could be determined as a matter of trust and confidence, so long as no reliance was placed on allegations which went to Dr MN's conduct and/or capability. In those circumstances, there could be no suggestion that this amounted to a side-stepping of E27 policy and procedures.

Relief

131. In my judgment, it would be appropriate to grant declaratory relief in this case which sets out the Court's finding as to the proper interpretation of Dr MN's contract of employment with respect to the identity of the Case Manager for this investigation. That relief will make it clear to the parties what the contractual requirements are, including the qualifications identified at paragraphs 109-110 above. I leave it to the parties to seek to agree the precise wording of that declaratory relief having read this judgment (which will initially be provided to them in draft for the purposes of typographical corrections). If no agreement can be reached, the Court will determine the matter.

Conclusion

132. For the reasons set out above, Dr MN succeeds on his claim. It is a term of Dr MN's contract of employment that the Case Manager should be the Medical Director (in this case, the Chief Medical Officer) for the matters that are the subject of the present investigation; and the Trust must ensure that Mr Z carries out that role once the investigation has been completed unless one of the exceptional circumstances that justifies departure from that requirement applies.