Report of CHRE s29 Pilot Study

Note for readers – CHRE comment

It should be noted that the statistics provided in this report relating to the erasure of practitioners and the number of cases notified to CHRE are not entirely accurate for the following reasons.

i) The report does not take into account that for part of the period covered the GMC did not notify CHRE of all cases resulting in erasure.

ii) The report makes comparisons with the number of removals from the registers of the GMC and the NMC. However, it is difficult to draw comparisons here as at the time of this report the NMC only had the option to caution a registrant or remove them from the register, whereas the GMC have the option of also suspending the registrant or imposing conditions on their registration.

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Executive Summary

This document reports on the pilot study into s 29 decision making processes.

It adopts an analysis of the decision making process to identify where key decisions are taken (1) whether any action at all is required by CHRE, (2) whether further information is needed for exercise of the s 29 powers to be considered, (3) whether on review of information the matter should not be referred to a s 29 case meeting, (4) whether on review at a s 29 case meeting the matter should be referred to court.

The numbers of referrals are rising, with most coming from the GMC and NMC. A comparison of disposals in relation to GMC and NMC cases for the period 1.10.03-31.12.03 is instructive: It reveals that CHRE staff are considerably more involved with exercising judgment in relation to GMC referrals than in relation to NMC referrals. In most (60%) of the latter cases, there was no jurisdiction to refer, mainly because the sanction applied was removal from the register (Figure 2). In 73% of GMC cases in this period, a judgment was necessary by CHRE officer, although no further information was thought necessary (Figure 3).

The process is working smoothly, although there were some early difficulties. Decision making within CHRE was prompt, with initial decisions on whether further information was required averaging 2 days, directors' decisions on whether to refer to a case meeting, once further information was received, averaged only one day.

The Scrutiny Committee can have reasonable assurance from this pilot study that documentation is now reliable and provides a satisfactory audit trail for decisions. The weakest area is minutes of section 29 case Meetings.

Recommendations:

With the clarification of criteria recently offered by the Court of Appeal, guidance for s 29 meetings should be reviewed and made more detailed (see 1.1, 4.1).

Examination should be made of why different regulators' use of the most serious sanctions seems to differ.

Quarterly analysis be undertaken of disposals through the five stage filtering process (see 2).

A standard should be agreed with the regulatory bodies for determinations to be referred to the CHRE, with monitoring on a quarterly basis. Such a standard could be defined in terms of 90% of cases being referred within 3 days, 100% within 7 days. (see 2.1)

Consideration be given to a standard form for recording the outcome and reasons for decisions at s 29 case meetings (see 3).

Introduction

This project aims to audit the paperwork held by the CHRE concerning the s 29 powers. Its objective is to evaluate on a pilot basis the process by which decisions are made within CHRE for consistency, reliability as measured against CHRE policy and acceptability of outcome (as agreed by the Scrutiny Committee meeting held on 21 July 2004).

This pilot study was conducted within a budgetary limit of £3,000. It comprised a review of a sample of 180 CHRE files, (approximately 43% of the total files). These included files on 31 cases considered by Directors but not resulting in a section 29 case meeting, and the files of 15 cases in which a section 29 case meeting was held. I reviewed the spreadsheets used to record and monitor progress on cases referred to the CHRE by regulators and have extracted some quantitative data from those spreadsheets on a sample basis to explore monitoring criteria. I was also able to discuss the processes with Sandy Forrest, Julie Stone and Michael Andrews. I am particularly grateful to Michael for his assistance in navigating the files and clarifying points of confusion for me. The legislation and the court judgments upon it were also read and considered.

The outcomes of the pilot study were to be

1. A mapping of the decision making process to identify where key decisions are taken (1) whether any action at all is required by CHRE, (2) whether further information is needed for exercise of the s 29 powers to be considered, (3) whether on review of information the matter should not be referred to a s 29 case meeting, (4) whether on review at a s 29 case meeting the matter should be referred to court.
2. Review of the pattern of disposal of cases within this framework, including an initial trend analysis on a quarterly basis 01/09/03-31/08/04 to identify appropriate measures on which monitoring might be based.
3. Advice to the Scrutiny Committee on the reliability of the documentation held by CHRE as an audit trail.
4. Advice to the Scrutiny Committee on the implicit and explicit criteria which seem to have been used, the consistency with which those criteria seem to have been applied, and the degree of congruence between those criteria and those suggested by the legislation, and judicial interpretation.
5. Recommendations to the Scrutiny Committee as to any changes in procedure or policy or further work indicated by the pilot study.
6. Identification of possible learning points from the materials reviewed.

The report is arranged around these outcomes.

1. Outcome 1: decision making processes

1.1 Decision making process on potential s 29 cases

The decision making process in relation to potential s 29 cases within CHRE can be broken down into a series of stages. These are slightly different from the phases identified in the Consultation Document, but they have been adopted because the appropriate criteria at each stage seem slightly different, given the risks being managed (see the commentary for outcome 4 below). They have also been selected because they enable comparisons to be made across time, even where the interpretation of the legislation and substantive criteria are in the process of being refined by the CHRE and the courts.

1. **Examination of jurisdiction.** At this stage cases are filtered out because there is no technical possibility of a s 29 referral. These are
    a. cases where the regulator has imposed the most serious available sanction, so that no increased protection of the public could be obtained. Most cases excluded at this stage fall into this category.
    b. cases where proceedings are not yet concluded (excluded by s 26(3) & (4) NHS Reform and Health Care Professions Act 2002)
    c. a few early cases are excluded where there was a perceived lack of jurisdiction due to acquittals by the regulatory body, prior to the establishment that this was not the true legal position in the Ruscillo case on 29 March 2004 (*Council for the Regulation of Health Care Professionals v GMC* [2004] EWHC 527).
    d. Cases where CHRE was informed too late to be able to consider referral to court.

    The decision required by the CHRE in this category does not entail any discretion. The first filtering stage concerns those cases rejected as being outside the jurisdiction of s 29. This stage is described as the clerical check in para 2.13 of the proposals document: *Protecting the Public: Decisions to Refer Regulatory Cases to Court* (CRHP 2003) but is in fact slightly more than a clerical task, as it requires a reasonably detailed understanding of the regulatory regimes under which determinations are made (e.g. for some regulators a wider range of sanctions is available than for others). This is recognised in the October 2004 proposals in paragraphs 12 & 13 which separate purely clerical checking from the first stage of assessment by a CHRE officer. If regulatory regimes become more consistent in terms of powers and sanctions, this task would become less technical.

2. Examination of cases within the jurisdiction to see whether there is an **issue that requires further consideration**. Here a fitness to practice manager at CHRE will filter out a proportion of cases as not requiring further consideration as a matter of discretion, with a Director confirming the decision. Criteria for the exercise of this discretion can be identified from the reasons given on the file for not requesting further information from the

regulator. These usually related to the questions suggested in para 2.14 of the 2003 consultation document

a. Actual or potential harm to the public
b. Which members of the public are at risk of harm
c. Whether there is a real risk of harm
d. What other decision was available to the regulatory body

These raise areas for consideration rather than provide criteria to govern decisions. There is no clear standard of proof or risk threshold. While an audit of the files indicates that these questions are usually referred to, they are more easily used to explain why a case does or does not need further examination than as a definition of the statutory criteria for a referral to court.

There is little evidence in the files that officers found the factors set out in para 2.17 and 2.18 helpful as a decision making framework, although a number of them were referred to: nature of lapses in clinical standards, sexual misconduct, dishonesty, eligibility to continue to practise, insight.

3. Further information, once received, will be considered by a Director to determine **whether the case should be referred to a case meeting**. At this stage, consideration is understandably case specific. The factors already identified are clearly relevant, but the test suggested in the Consultation Document refers to the *strength* of the case and the *necessity* of referring the case to the Court (para 2.21). It is unclear from the Consultation Document and from a review of the files whether consideration of the prospect of success in a court hearing and issues of proof is expected at this stage.

4. A **case meeting** will consider whether the case should be referred to the High Court. This will normally be supported by a recommendation from the Director and a statement from the CHRE legal advisers. The panel is normally three members of council, although provision is made for fewer members in urgent cases (Consultation Document paras 2.39-2.42)

   The process at s 29 Meetings seems now to have established a settled pattern being set out in advice from lawyers (e.g. Bevan Ashford, 2 July 2004 for 261/2004, but similar to that given by other lawyers servicing section 29 meetings). This pattern envisages the following stages

   1. Which provision of s 29(4) is to be relied upon
   2. Does CHRP consider any finding of fact or lack of such finding unduly lenient or otherwise wrong.
   3. Does CHRP consider the penalty unduly lenient.
   4. If so, what should the minimum penalty have been
   5. Is it desirable for the protection of members of the public to refer the case to court.

   Recommendation: With the clarification of criteria recently offered by the Court of Appeal, this guidance should be reviewed and can be made more

detailed. This could be commissioned once and CHRE need not pay for it again in relation to each s 29 meeting.

Outcome 2: Disposal of cases

Analysis of cases by regulator divided into the seven months prior to 31.3.04 and the nearly similar period 1.4.04 to 15.10.04 suggests that the volume of referrals is increasing, with significant increases in relation to the GMC and NMC.

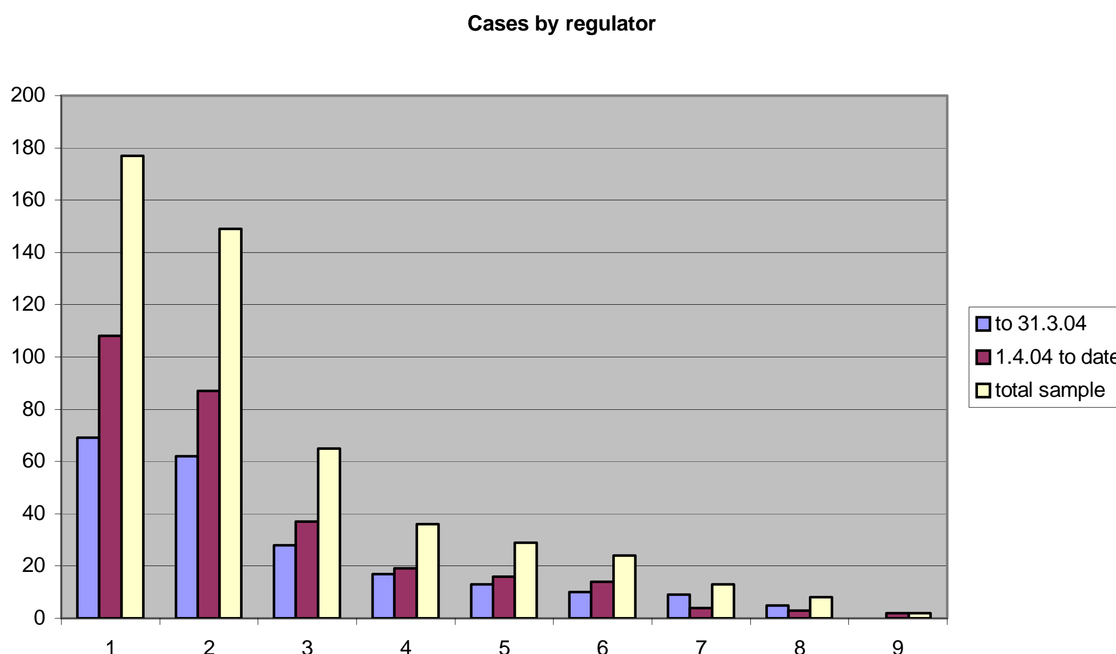

Figure 1 Cases referred, by time period and regulator

1. GMC	4. GDC	7. GCC
2. NMC	5. HPC	8. GOstC
3. RPSGB	6. GOC	9. PSNI

Further analysis of disposals by regulator may reveal some interesting patterns. It has not been possible in this pilot study to analyse all the data, but a comparison of disposals in relation to GMC and NMC cases for the period 1.10.03-31.12.03 is instructive: These two regulators were chosen because they were the source the largest number of decisions referred to CHRE in the period being studied. Comparison reveals that CHRE staff are considerably more involved with exercising judgment in relation to GMC referrals than in relation to NMC referrals. In most (60%) of the latter cases, there was no jurisdiction to refer, mainly because the sanction applied was removal from the register (Figure 2). In 73% of GMC cases in this period, a judgment was necessary by CHRE officer, although no further information was thought necessary (Figure 3). This seems a significant variation that merits further consideration. Variations in relation to cases where information was sought but no meeting was considered necessary, or in relation to referral to the courts are not thought significant bearing in mind the small numbers. It would also be appropriate to undertake similar analysis of cases concerning other regulators once the numbers reach a level that makes consideration meaningful.

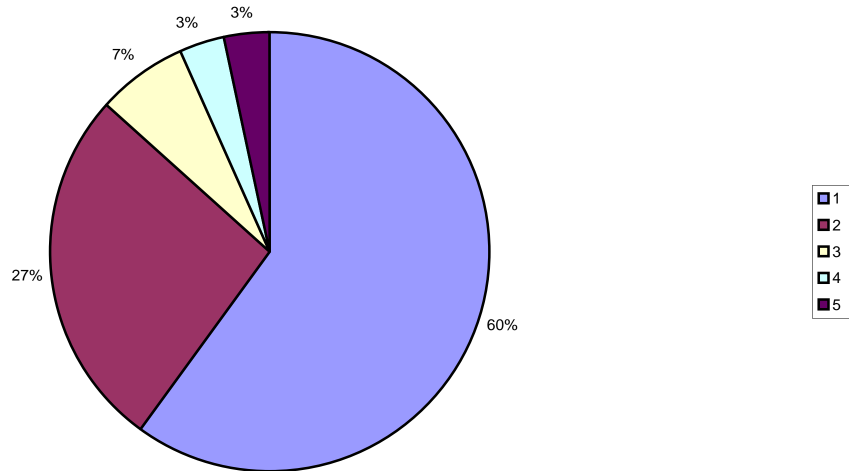

Figure 2: Disposal of NMC Cases

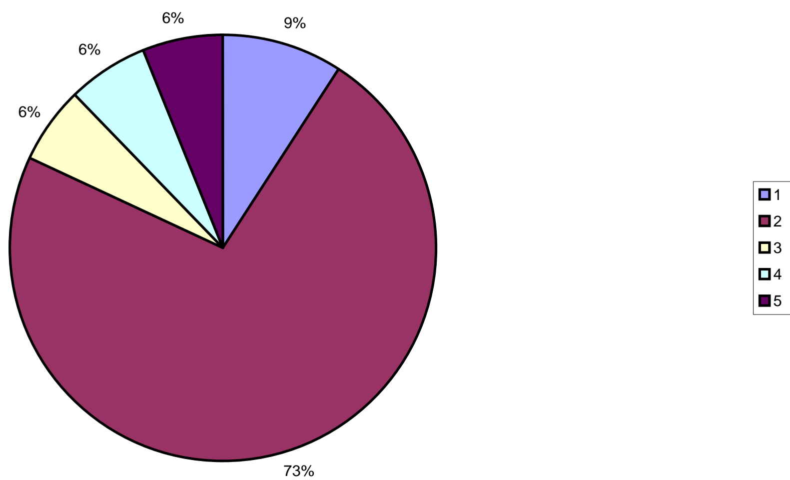

Figure 3: Disposal of GMC cases

1. lack of jurisdiction
2. no further information
3. no meeting
4. no referral
5. referral

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It is recommended that quarterly analysis be undertaken of disposals through the five stage filtering process. It is suggested that it is helpful to subdivide the ‘no further action’ category (as used in Chart 10 in the paper Section 29 Statistical summary’ as Item 7 for the meeting of 25 October 2004) into ‘lack of jurisdiction’ cases and cases where there is a judgment that the case needs no further action without the need for further information because it enables the risks outlined in 1.3 above to be considered more clearly. Full analysis of past quarters could be commissioned to enable trend analysis to be made at an early stage, or it could be carried out only prospectively.

2.1 Process efficiency

Powers under s 29 need to be exercised within four weeks of the date of the determination by the regulatory body (s 29(6)). Consequently systems for handling cases referred to the CHRE must be effective to meet this deadline. Analysis of the data indicates that the system is now working smoothly, although there were some difficulties in the early stages.

There were a very few cases from early in the operation where it seems that there were process failures obstructing the effective use of the s 29 powers. Decisions timed out due to internal administrative failure (6/2003, 14/2003, 69/2003). More commonly, the process failures arose where the Regulatory bodies failed to supply information requested within the timescale required for a decision (8/2003, 15/2003, 32/2003, 247/2004, 248/2004). In 291/2004 the information was supplied after 19 days and there was insufficient time for CHRE to make an informed decision.

Current performance seems consistently more satisfactory and provides sufficient time for decisions to be taken within CHRE, but some variation remains as indicated below:

Length of time taken to inform CHRE 01.04.04-17.09.04

Regulatory Body	**Working Days**
GMC	1.9
HPC	3
NMC	9
GDC	1.8
GOC	3.5
GOstC	5
GCC	2
PSNI	7.5
RSPGB	4.8
Average of all cases	**4**

Length of time for transcripts to be received from regulators following a request 01.04.04-17.09.04

Regulatory Body	Working Days
GMC (n=17)	6
HPC (n=1)	3
NMC (n=3)	7
GDC (n=5)	3
GOC (n=5)	6
GOstC	-
GCC (n=1)	8
PSNI (n=1)	7
RSPGB (n=7)	2
Average of all cases	5.5

Decision making within CHRE was prompt, with initial decisions on whether further information was required averaging 2 days, directors' decisions on whether to refer to a case meeting, once further information was received, averaged only one day.

In order to ensure that decisions can be taken in a timely manner, it is recommended that a standard be agreed with the regulatory bodies for determinations to be referred to the CHRE, with monitoring on a quarterly basis. Such a standard could be defined in terms of 90% of cases being referred within 3 days, 100% within 7 days.

This does not seem to be an area for significant concern, but it would perhaps be helpful for performance targets to be set and monitored to ensure that the promptness of the current system is maintained. It does not seem to be necessary to set a standard for supply of further information at this stage as the bulk of requests are made to the GMC which appears to have an effective system in place, although in one case it took 13 working days for the information to be supplied.

Outcome 3: Reliability of audit trails

There were a few early cases in the sample in which the audit trail was lacking (4/2003 – no evidence of consideration, no decision recorded; 20/2003, 27/2003, 28/2003 – no evidence of consideration). In general a reading of the files does not suggest that these were cases where the public had not been protected, however in 30/2003 no evidence of consideration of transcript after received and no decision recorded in a case where there had been serious failures to provide adequate facilities that would have put patients at risk. The General Dental Council concluded that there was no serious professional misconduct, citing improvements. This would seem to have been a matter going to sanction rather than misconduct itself, and it is unfortunate that the CHRP does not seem to have considered this case fully.

The recording of the later cases sampled was sufficiently full to show the audit trail. No missing files were identified and only three were misplaced close to the correct position and were easily located (265/2004, 270/2004, 281/2004). A few minor lapses in completeness were identified. These may reflect the paper files not having copies of all the electronic communications

> In 262/2004 it was not clear why a meeting had been arranged, there having been discussion of whether it was necessary that seems unresolved.
>
> 297/2004 the file contains no record of why no meeting was required. There seems to have been no public protection issue identified, but there is no record of the reasoning.
>
> In 183/2004 and 146/2004 no minutes were in the file of the s 29 meeting. In 40/2003 there were no minutes and in addition no record of the director's oral report to the meeting. Consequently, the reasons for the decisions not to refer cannot be identified and the Council would be at risk if it transpired that the practitioners concerned harmed patients in the future.

The Scrutiny Committee can therefore have reasonable assurance from this pilot study that documentation is now reliable. The weakest area is minutes of section 29 case Meetings. It is *recommended* that consideration be given to a standard form for recording the outcome and reasons for decisions at s 29 case meetings. It may be that inviting lawyers from a number of different firms to draft minutes has delayed the settling of a reliable standard format.

Outcome 4: Consistency and criteria

4.1 External guidance on appropriate criteria

Some evidence on proper approach to cases may also be gained from an analysis of the Court judgments. This guidance has been of limited use in analysing the decisions considered in this pilot study, as many were taken before the High Court decisions handed down in March 2004. None were able to take into account the decision of the Court of Appeal handed down on 20 October 2004. This section considers this guidance from the Court of Appeal in terms of any indications for a change in practice or for further work. It represents an analysis by the researcher for the purposes of this study and should not be taken as formal advice on the state of the law. It should be noted that other lawyers might take a different view of the implications of the decisions.

Most importantly, Collins J in the Truscott case was satisfied that the CRHP had been correct to refer the case to the court and the Court of Appeal seems to have endorsed that assessment (*Ruscillo v CHRE & GMC; CHRE v NMC & Steven Truscott* [2004] EWCA Civ 1356). Although both courts reached the view that the decision of the

NMC that Truscott should be cautioned rather than struck off was not unduly lenient Collins J regarded the case as borderline and was not critical of the CHRE for referring it (*CRHP v NMC* [2004] EWHC 585 at [28]). This should be seen as giving some reassurance to the Scrutiny Committee that the CHRE processes are delivering appropriate outcomes.

The High Court decision in the Truscott case set down a more limited cope for referral to court than the Court of Appeal. Collins J suggested, para [10]-[11], that the 'undue lenience' and should be determined as in criminal appeals by asking 'whether the penalty falls outside the range of penalties which the committee, applying their mind to all the relevant factors, could reasonably consider appropriate.' (*CRHP v NMC* [2004] EWHC 585). This seems to have been applied in s 29 case meetings subsequent to the decision.

The Court of Appeal found that there were two bases on which a section 29 appeal could succeed, and which should therefore now be taken into account in internal CHRE procedures.

(a) Substantive grounds – that the decision as to penalty was 'wrong' (para [71]). This is elaborated as meaning

> 'whether, having regard to the material facts, the decision reached has due regard for the safety of the public and the reputation of the profession' (para [73])
>
> 'whether it is one which a disciplinary tribunal, having regard to the relevant facts and to the object of the disciplinary proceedings, could reasonably have imposed.' (para [76])
>
> 'whether the disciplinary tribunal has reached a decision as to penalty that is manifestly inappropriate having regard to the practitioner's conduct and the interests of the public.' (para 77).

In the researcher's view, this is less restrictive on the exercise of powers under s 29 than the Collins formulation in that it must be reasonable actually to impose the penalty rather than a more serious sanction, not merely reasonable to have 'considered' it. It also draws attention more clearly to the public protection issues.

(b) 'serious procedural or other irregularity' which prevents the court deciding whether the decision as to penalty was appropriate (para [72].

This was mainly discussed in relation to issues of 'under prosecution' in the Ruscillo case. However, it was also relevant in Truscott where the Court of Appeal found that, contrary to the view taken by CHRE that the NMC's PCC had addressed its mind to the risks to the public arising from Truscott's misconduct.

One important factor in the Court of Appeal's analysis was its acceptance that the risk presented by Truscott should he continue to work as a nurse was one that should be

seen as a matter whose assessment required professional expertise (para [78]). This would imply a reluctance to permit a lay assessment of risk, despite the fact that the risks did not arise out of any technical nursing expertise but from whether an interest in pornography does in fact raise a risk that the person interested would act inappropriately towards young people in their care.

Recommendation: With this clarification of criteria from the Court of Appeal, this guidance for s 29 meetings should be commissioned once and CHRE need not pay for it again in relation to each s 29 meeting.

4.2 Qualitative analysis of material audited

Analysis of the handling of cases can be made by tracking the disposal of cases, identifying where they are filtered out in the stages identified above.

1. excluded by a fitness to practice manager (signed off by Director) for **lack of jurisdiction**. Here the decision is essentially one of categorisation and the essential criteria for effectiveness are promptness and accuracy of categorisation. The precise criteria for jurisdiction have changed over the period examined because of judicial decisions, e.g. concerning whether findings of not guilty are within the s 29 jurisdiction, but using a category of lack of jurisdiction allows comparability in terms of the CHRE's handling of cases.

   The key risk to CHRE here is that cases are wrongly excluded. If they are wrongly included, this can be picked up at a later stage in the process, and the only unnecessary cost is in terms of CHRE resource rather than public protection. Erroneous exclusion could leave the public poorly protected and damage the reputation of the CHRE and the original regulator if it later transpires that a registrant harms patients when permitted to continue in practice.

   No errors at this stage were identified in the sample.

2. excluded by a fitness to practice manager (signed off by Director) because **no further information is thought necessary**. This involves an exercise of judgment on the part of the fitness to practice manager, which necessarily has to be taken on a minimal amount of information about the cases in question. Key criteria at this stage will be promptness, proper application of s 29 criteria, clear audit trail.

   Again, the key risk to CHRE here is that cases are wrongly excluded. If they are wrongly included, this can be picked up at a later stage in the process, and the issues relate to CHRE resource rather than public protection. Erroneous exclusion could leave the public poorly protected and damage the reputation of the CHRE and the original regulator if it later transpires that a registrant harms patients when permitted to continue in practice.

The audit of CHRE practice suggests that there is consistent practice here, but that consideration could be given to a more explicit standard of proof required to trigger a request for further information. This could be phrased in terms of concern caused by the apparent presence of risk factors, apparent 'internal' inconsistency of regulator's practice, or apparent procedural defects. This decision has to be taken on minimal information and nothing higher than concern because of an issue is apparent rather than clearly present would be practicable.

3. excluded by a Director as **not needing a case meeting**. Here, the Director needs to exercise a key judgment as to whether a determination is unduly lenient or not.

   It is recommended that the CHRE considers two models for this stage of the process

   (a) does it wish this stage to be the linchpin of its system? This would place the principal burden of deciding whether a decision should be referred on the Director, with main function of the s 29 meeting to monitor the exercise of discretion by the Directors and to ensure that court referrals are not made inappropriately. This would flow naturally from a concern to protect the CHRE and regulators from unnecessary court action, and control costs. On this model the expectation would be that cases would be brought to a case meeting with a reasoned recommendation to referral. If this model is adopted, then the Director should consider the criteria as set out by the Court of Appeal.

   (b) whether all cases where there is an arguable case of undue lenience should be considered by a s 29 meeting. Here the main responsibility for protecting the public falls on the s 29 meeting and it would be expected that its workload would be significantly higher than in model (a). The role of the director would be to identify cases for consideration, rather than cases where in his or her view a referral was called for. The report of the Director would not necessarily make any recommendation to the meeting, but would aim to draw attention to the key considerations.

   There is some evidence from the files that greater clarity could be achieved of when the Scrutiny Committee wishes a section 29 meeting to be convened. In 221/2004, 225/2004 and 219/2004 the s 29 meeting declined to take a decision on cases where suspension had been ordered on the basis that there was no current public protection issue during the period of suspension. It declined to consider whether suspension was sufficient to deal with child pornography. This effectively deferred consideration of the substantive issue, leaving the Director without guidance. If only the 'jurisdictional issues' over whether current protection was sufficient needed consideration, then this could have been excluded at a much earlier stage. This may reflect the impact of Truscott and Solanke in the High court and the legal advice offered on the restrictive tests they set out.

4. excluded by a case meeting as not needing referral to courts. Here, the key risks can be analysed as failure to protect the public if referral is not made when it should have been.

   Minutes of s 29 meetings were not always clear, as to the criterion applied and findings on key issues and were sometimes absent from the file (see above). It has been recommended that a standard format be drawn up for recording decision.

5. cases that are **referred to the court**. See above for the analysis of the judicial comments.

4.3 Substantive analysis

So far as it was possible to tell from the paperwork, the judgement exercised by Council officers, directors and s 29 case meetings was consistent and appeared sound.

In the sample audited, I identified only one case where I had some concern over the substance of the decision. This was **05/2003**, which did not proceed to further consideration despite being a case of 'abuse of position' in relation to sale of products. It is not clear from the limited information received by CHRP what degree of risk was presented to the public of reoccurrence. Possibly further information should have been sought in the form of a transcript. There were a number of indications that 'victimless' fraud – where no individual patients were put at risk, but NHS finances were concerned – was not seen as significant so far as s 29 is concerned. There seems to have been an implicit decision to regard the 'public interest' as referring to the interests of individual members of the public rather than the collective interests in efficient services. It is not clear whether this has been the subject of specific decision within the Council.

Possible areas of future work

1. A search of the Lexis-Nexis database (21 September 2004) indicates that since 1 January 2003 a significant number of legal cases have been heard involving the health regulatory bodies. Many of these would include consideration of regulatory processes and sanctions. They include 53 cases involving the GMC, 10 involving the NMC, 2 involving the GDC, one involving the Royal Pharmaceutical Society of Great Britain, one involving the Health Professions Council, and one involving the General Osteopathic Council. Many more older cases have been decided and are available on the legal databases. One possible area of work would be an examination of this body of case law to identify judicial comments on regulatory practice.

2. The analysis of disposals in relation to GMC and GMC cases suggests that a different proportion of cases result in the severest available sanction being applied. This merits further consideration. There are many possible explanations. Cases may

not easily be comparable but it would be appropriate to consider whether there is any objective basis for determining whether regulators deal differently with similar cases.

3. It is not possible to analyse issues of diversity from the data held by the CHRE. This may give rise to concerns in relation to the Council's obligations under the Race Relations Amendment Act. The data necessary to categorise activity by race, gender or age is held by the regulators, and possibly not even by them. Consideration could be given to a study of diversity issues through the whole regulatory system, including any CHRE issues. There has been criticism in the past of the way in which the ethnic minority professionals are treated within the system, but this may be more accurately be correlated with the place of qualification than ethnicity alone.

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