Neutral Citation Number: [2022] EWHC 1141 (Admin)

Case No: CO/3486/2020

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
ADMINISRATIVE COURT

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 13/05/2022

Before:

MRS JUSTICE HILL

- -

Between:

R (PROFESSOR PAUL TAGGART)	**Claimant**
-and-	
THE ROYAL COLLEGE OF SURGEONS OF ENGLAND	**Defendant**
-and-	
OXFORD UNIVERSITY HOSPITALS NHS TRUST **THE GENERAL MEDICAL COUNCIL** **THE SOCIETY OF CARDIOTHORACIC SURGEONS**	**Interested Parties**

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Jeremy Hyam QC and Natasha Barnes (instructed by Radcliffes LeBrasseur LLP) for the Claimant
Simon Gorton QC and Iain Steele (instructed by Markel Law) for the Defendant

Hearing date: 5 April 2022

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Approved Judgment

I direct that pursuant to CPR PD 39A para 6.1 no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

Covid-19 Protocol: this judgment was handed down by the judge remotely by circulation to the parties' representatives by email and release to The National Archives. The date and time of hand-down is 10.30am on 13 May 2022

Mrs Justice Hill:

Introduction

1. The Claimant is a cardiothoracic surgeon employed by Oxford University NHS Foundation Trust (the Trust). By this claim he seeks judicial review of a report dated 10 July 2020 produced by the Defendant, the Royal College of Surgeons (the RCS), and their refusals to withdraw or correct the report, as set out in letters dated 12 August and 15 September 2020. The report was provided as part of the Invited Review Mechanism (IRM) conducted by the RCS.

2. On 28 May 2021 Jay J granted the Claimant permission to apply for judicial review. He later directed this hearing of the preliminary issue of whether the IRM is amenable to judicial review. The Claimant relied on witness evidence from Dr Roger Palmer (Medicolegal Consultant Team Leader within the Medical Protection Society (MPS)) who has advised the Claimant and several other MPS members in cases where an IRM has been carried out. The RCS relied on witness evidence from Professor Timothy Rockall (Chair of its IRM) and Dr Adam de Belder (Medical Director of the Royal College of Physicians' Invited Review Service).

The facts

The RCS and the IRM

3. The RCS was established by Royal Charter in 1800 for the study and promotion of the art and science of surgery. It is an independent professional membership body and a registered charity. It is funded through membership fees, income generated from its activities and investments, charitable donations, grants and legacies. The RCS provides education, assessment, development and support to surgeons, dental surgeons and members of the wider surgical and dental teams at all stages of their career. It also sets professional standards, facilitates and funds surgical research and champions world-class surgical trials for patients.

4. One of the functions the RCS has assumed is to offer its IRM service to healthcare organisations. In summary, the IRM is a process by which an external expert opinion in relation to surgical standards is provided, under private contractual arrangements, for a fee. The RCS has offered this service since 1988, together with the ten Surgical Specialty Associations (SSAs).

5. An IRM can only be initiated upon formal request by a healthcare organisation, not individual surgeons or staff members. IRMs are conducted pursuant to private contractual arrangements between the RCS and a commissioning healthcare organisation. The healthcare organisation must make a formal request for review, must agree to the conditions set out in the Handbook and must pay a fee which depends on the nature and scope of the review. It is only if the review request passes the necessary threshold set by the IRM Chair and the relevant specialty member of the IRM Oversight Group that it will be deemed appropriate for a review to be carried out. Even then, because it is a privately contracted service, there can be circumstances in which a request for a review is declined by the RCS.

6. The IRM is seen as giving a "fair, independent professional review" to "support, but not replace" a healthcare organisation's own procedure for managing surgical performance or the

processes of any formal regulatory body. Professor Rockall's evidence was that the IRM is a "valued service" for healthcare organisations because it "promotes early action to address potential concerns, offers flexibility as to the nature and scope of the review, is peer and patient led with the interests of patient safety at the heart of every review and is specialist, independent and expert".

7. The RCS provides three different types of IRM: (i) a service review, which relates to the way a surgical service is being delivered and how this might be improved; (ii) an individual review, which relates to an individual surgeon's alleged unsatisfactory surgical practice; and (iii) a clinical record review (CRR), which relates to whether the management of a specific case or series of cases has met the required RCS or specialty association standards.

8. The IRM is described in the RCS's *Invited Review Handbook*, most recently published in 2018. The Handbook sets out certain procedural requirements. For example, it is specified that the review, though not formal, will be carried out in an open, fair and structured manner and that all relevant documents relied on by the healthcare organisation and given to the reviewers will also be made available to the surgeon being reviewed and vice versa.

9. The review team in an individual review normally consists of two surgeons and one layperson. In a CRR, the team usually consists of two surgeons. The terms of reference setting out the scope for an individual review must be shared with the surgeon under review in advance of the visit. The surgeon is asked to confirm in writing that they agree to participate in the review and that they have been fully informed by the organisation of its purpose and arrangements. No such provision is made for a CRR.

10. An individual surgeon whose performance has been reviewed under an IRM is not a party to the contract. The report is not in the first instance sent to the surgeon. If the IRM identifies any circumstances where an individual's performance is considered unsatisfactory and patient safety is thought to be at risk, appropriate recommendations will be made for consideration by the commissioning healthcare organisation. In addition, the IRM may recommend (and did here) that the organisation inform patients about the safety risk, pursuant to the duty of candour provisions. These provisions are derived from the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 20.

11. Once a report has been sent to the commissioning organisation, it becomes the organisation's property. Responsibility for considering what if any action to take consequent on the report rests solely with the commissioning organisation. The Handbook makes clear that "invited review arrangements are not regarded as an abrogation of, or a replacement for, the healthcare organisation's own decision making and disciplinary procedures which must strictly be applied according to their terms". It is also clear that "[i]nvited review reports are advisory and their recommendations are for consideration by the healthcare organisation commissioning the review". That said, the Handbook indicates that where concerns about patient safety are identified and reported to the commissioning healthcare organisation, the organisation "will consider and act on all the review team's recommendations", as well as ensuring that when doing so all other places in which the surgeon provides a surgical service are made aware of the review's recommendations.

12. The Handbook emphasises that the healthcare organisations remain entirely responsible for all decisions or subsequent actions, upon which it is urged to seek appropriate legal advice. It also requires the healthcare organisation to provide feedback to the RCS on the progress made

on implementing the recommendations from the report when the RCS request the same. It is said that the RCS will normally follow up actions taken with the healthcare organisation during the six months after the final report has been provided to them. If the healthcare organisation decides against implementing the review's recommendations it is said that the organisation should be prepared to fully explain its reasons for so doing.

13. The Handbook also makes provision for openness and transparency. It is said that where patient safety risks or other issues related to the quality of patient care have been identified, the RCS "expects" the healthcare organisation to make available to the public a clear summary of the review that has taken place and the steps the organisation is taking to address the issues and the applicable recommendations.

14. There are a number of regulatory bodies that deal with fitness to practise and disciplinary issues in relation to healthcare professionals. The RCS is not a healthcare regulator. It is no part of the RCS's role to investigate or take action in respect of the fitness to practise of individual surgeons or to impose measures and sanctions against NHS Trusts. The General Medical Council (GMC) is the independent statutory regulator that maintains the register of medical practitioners within the United Kingdom. The GMC's chief responsibility is to protect, promote and maintain the health and safety of the public by controlling entry to the register and suspending or removing members when necessary. The Care Quality Commission (CQC) is the independent regulator of health and adult social care in England. The CQC registers care providers, monitors, inspects and rates services and takes action to protect people who use those services.

15. However, the RCS, the SSAs and the reviewers reserve the right, in the public interest, to disclose the results of an IRM and advice given to a regulatory body such as the GMC or Care Quality Commission (CQC), if they are not satisfied that the commissioning organisation has taken appropriate steps or is not fulfilling its statutory duties to patient safety. This "reservation" of the right to refer is set out in several parts of the Handbook.

16. The commissioning organisation is required to indemnify the RCS and the reviewers undertaking the review by signing a Deed of Indemnity. This deed also reiterates the reservation of the right to refer.

17. The IRM is overseen by an Oversight Group which has responsibility for quality assuring draft IRM reports. A member of the Practitioner Performance Advice (PPA) service (formerly the National Clinical Assessment Authority) sits on the Oversight Group. The PPA also has a specific role before any formal conduct or capability hearing in relation to a doctor, in accordance with Maintaining High Professional Standards in the NHS (MHPS). MHPS is a collective agreement that was agreed and published by the Department of Health in 2003 as a contractual framework for handling concerns about doctors and dentists within the NHS. Where it is contractually applicable, MHPS prescribes the procedure and substantive steps an employer must adopt when dealing with matters of conduct, capability and ill mental health.

18. The former President of the RCS, John Black, gave evidence to the Mid-Staffordshire Inquiry in June 2011 to the effect that the RCS strongly supported proposed regulations which would implement a statutory duty of co-operation relating to the sharing of information about the conduct or performance of healthcare workers. In 2012 the Department of Health indicated that it did not intend to proceed with the draft regulations.

19. In addition to the RCS, eleven other Royal Medical Colleges undertake invited reviews, which are substantially similar to the RCS's IRM. To promoted consistency between these schemes, the Academy of Medical Royal Colleges (AOMRC) published *A framework of operating principles for managing invited reviews within healthcare* in January 2016. The AOMRC framework was drawn up following the publication of Dr Kirkup's independent investigation into the provision of neonatal services at Morecambe Bay NHS Foundation Trust on 3 March 2015. Recommendation 44 of this report had noted the "ad hoc nature and variable quality" of the "numerous external reviews of services" considered in that case, such that "systematic guidance…setting out an appropriate framework for external services and professional responsibilities in undertaking them" should be drawn up. The various Colleges and other professional bodies undertaking invited reviews in this way agreed the AOMRC framework. The GMC and CQC also contributed to it. The principles identified in the AOMRC framework include that invited reviews are "advisory" (principle 5) and that they are "voluntary" (principle 6).

The IRM with respect to the Claimant

20. The Claimant has been employed by the Trust or its predecessors as a consultant cardiothoracic surgeon since 1995. He is primarily based at the John Radcliffe Hospital but had a fortnightly out-patient clinic at Northampton General Hospital.

21. In 2019 the Trust asked the RCS to carry out a CRR in relation to patient MC. This patient had been transferred from Northampton General Hospital to John Radcliffe Hospital the day before being treated by the Claimant. The Claimant was not given any opportunity to comment before, on 4 November 2019, the RCS completed its report and sent it to the Trust. The accompanying letter from Professor Rockall recommended that the Trust consider further discussion of the circumstances with the relevant GMC Employer Liaison Advisor (ELA) and sought confirmation that this had taken place. The Trust gave that confirmation. The Claimant makes complaint that although the report records that the Trust had provided the RCS with copies of relevant clinical records it appears that the RCS had not received copies of the Northampton General Hospital records

22. On 27 November 2019 the Trust provided the Claimant with a copy of the CRR report. The Claimant duly provided detailed comments on it. The Trust decided to ask the RCS to carry out an individual review in respect of the Claimant. The Trust also restricted the Claimant from clinical work. It is said that these restrictions were imposed under an implied term of the Claimant's employment contract with the Trust. This is the subject of dispute in separate civil proceedings the Claimant has brought against the Trust.

23. On 20 January 2020, the Claimant consented to the individual review. On 29 January 2020 he was informed of the terms of reference of the review. It was said that the review would involve consideration of background documentation relevant to his clinical practice and the concerns raised, a clinical record review of up to seven index cases put forward by the Trust and interviews with him and a number of his colleagues at the Trust.

24. Towards the end of the week commencing 3 February 2020 the Trust provided the Claimant with access to some of the clinical records for the seven patients whose cases were to be subject to review. He identified as missing certain records from Northampton General Hospital, some of the records from John Radcliffe Hospital, electronic ward records for

patients A1, A2, A4, A5, A6 and A7, the record of the Multi-Disciplinary Team documentation relating to patient A1 and A7 and pre-operative assessment records.

25. On 6 February 2020 MPS wrote to the Trust pointing out that the Claimant had not been given access to the records needed for him to participate in the review and that he was still on sick leave. It was still proposed that the RCS's reviewers would visit the John Radcliffe Hospital from 11-12 February 2020.

26. On 10 February 2020 MPS informed the RCS that while the Claimant continued to agree in principle to the individual review, he did not agree to participate from 11-12 February 2020: he was on sick leave and a Trust occupational health review was due to collect take place on 18 February 2020.

27. At some point on 10 February 2020 the Trust asked the RCS to carry out a CRR as opposed to an individual review. The RCS agreed. The CRR visit took place on 11 February 2020. The Claimant complains that he was not informed of this development until a letter to MPS dated 17 February 2020.

28. The Claimant argues that the review that took place in his case was a form of hybrid between individual review and a CRR.

29. On 4 May 2020 the Claimant returned to work from his period of sick leave.

30. On 26 June 2020 MPS wrote to the Trust seeking the lifting of the restrictions on the Claimant's work imposed in November 2019. On 1 July 2020 the Trust indicated that they considered that the restrictions should remain in place as the RCS's final report had not yet been received.

31. On 10 July 2020 the RCS issued the CRR report that is the subject of this challenge and shared it with the Trust. The report identified a number of concerns in respect of the cases considered. It contained seven recommendations, including that the Trust take advice from the GMC ELA. It recommended that the Trust provide further follow-up of any patients where it considered this was necessary to protect patient safety and to ensure compliance with the duty of candour.

32. By letter dated 20 July 2020, the CRR report was provided to the Claimant. On the same day the Trust imposed restrictions on the Claimant's practice to the effect that he must not undertake any surgical activities. These restrictions were imposed pursuant to MHPS.

33. On 23 July 2020 the Trust submitted a referral of the Claimant to the GMC. By letter dated 3 August 2020 the GMC summonsed the Claimant to an interim orders hearing, for reasons which recited the RCS report's findings at length. It was not considered necessary to impose an interim order in respect of the Claimant.

34. On 30 July 2020 MPS wrote to the RCS pointing out what were described as procedural deficiencies in the RCS's process and consequential errors in the report. The MPS invited the RCS to withdraw or amend the report.

35. By letter dated 12 August 2020 Professor Rockall indicated that any requests for amendment to the report should be directed to the Trust, as only the Trust and not the Claimant could request an 'updated' report. The letter indicated that a CRR permits, though does not require,

the surgeon concerned to be interviewed. The Claimant complains that he was not given this opportunity despite the fact that he returned to work on 4 May 2020 and the report was not issued until 10 July 2020. Further, he asserts that it is inaccurate for the CRR to state in terms that he was not available to be interviewed "during the review", when in fact he was. The letter also suggested that four witnesses nominated by the Trust had provided "general contextual information" about the delivery of cardiac surgery. The Claimant complains that this information has not been disclosed in the report and goes beyond the involvement ordinarily expected in a CRR. The Claimant also highlights that the letter did not specify which clinical records the RCS had seen.

36. By a pre-action letter dated 27 August 2020, the Claimant invited the RCS to (i) withdraw the CRR on grounds of unfairness and procedural impropriety; and (ii) issue a revised report, having obtained the missing records and either taken into account the Claimant's account, or having removed the sentence to the effect that he was not available to be interviewed.

37. On 15 September 2020 the RCS replied indicating that it did not consider the CRR was amenable to judicial review or that it had acted unlawfully.

38. On 29 September 2020 the Claimant issued this claim for judicial review.

39. On 15 October 2020 the GMC confirmed to the Claimant that its investigation was being put on hold pending the outcome of this claim, because its decision to open a GMC investigation was "largely based on the RCS report".

40. On 17 February 2022 the Trust produced a confidential report under MHPS into the matters of concern raised by the RCS. The Claimant asked the Trust for permission to disclose this to the RCS and the Court The Trust has declined to give this permission.

The legal framework

41. Judicial review is generally not available in relation to employment matters: see De Smith, Judicial Review (8th Edition) at 3-072, citing several cases including *R v BBC, ex parte Lavelle* [1983] 1 WLR 23 to the effect that "[w]here a public authority takes action in relation to an employee, such as disciplinary action or termination of an employment relationship, this will normally be a matter for contract or employment law rather than judicial review".

42. In *Council of Civil Service Unions v Minister for the Civil Service* [1985] AC 374 at pp.408-9, Lord Diplock held the following:

> "To qualify as a subject for judicial review the decision must have consequences which affect some person (or body of persons) other than the decision-maker, although it may affect him too. It must affect such other person either:
>
> (a) by altering rights or obligations of that person which are enforceable by or against him in private law; or
>
> (b) by depriving him of some benefit or advantage which either (i) he had in the past been permitted by the decision-maker to enjoy and which he can legitimately expect to be permitted to continue to do so until there has been communicated to him some rational grounds for withdrawing it on which he has been given the

> opportunity to comment; or (ii) he has received assurance from the decision-maker will not be withdrawn without giving him the opportunity of advancing reasons for contending that it should they should not be withdrawn".

43. In *R v Panel on Takeovers and Mergers, ex parte Datafin Plc* [1987] QB 815 the Court of Appeal held that judicial review was no longer restricted to bodies which derive their powers from legislation or the prerogative. The Court concluded that it was relevant to look not only at the source of the power but also its nature. Lloyd LJ stated at p.847B-C that it may be sufficient to bring a body within the reach of judicial review if the body in question "is exercising public law functions, or if the exercise of its functions have public law consequences". Sir John Donaldson MR explained at p.838D that while it is possible to find "enumerations of factors giving rise to the jurisdiction" in the caselaw, it is a "fatal error to regard the presence of all those factors as essential or as being exclusive of other factors". He said that "[p]ossibly the only essential elements are what can be described as a public element, which can take many different forms, and the exclusion from the jurisdiction of bodies whose sole source of power as a consensual submission to its jurisdiction".

44. In *Datafin* the Court noted that although the Panel on Takeovers and Mergers lacked any authority *de jure*, it exercised "immense power de facto" (Sir John Donaldson MR at p.826C) or "enormous power" (Lloyd LJ at p.845F). This was because it made and interpreted the code on takeovers and mergers, determined whether beaches had occurred, laid down sanctions and had the power to refer a case to the Department of Transport and Industry or the Stock Exchange who could use statutory or contractual powers to penalise the transgressors.

45. In *R v Disciplinary Committee of the Jockey Club, ex parte Aga Khan* [1993] 1 WLR 909, the Court of Appeal considered whether the Jockey Club was susceptible to judicial review. At p.921B-C, Lord Bingham MR explained that the effect of *Datafin* was to "extend judicial review to a body whose birth and constitution owed nothing to any exercise of governmental power, but which had been woven into the fabric of public regulation". The Court concluded that the Jockey Club's decisions were not amenable to judicial review. Notwithstanding that the Club "effectively regulates a significant national activity exercising powers which affect the public and are exercised in the interests of the public", it was "not in its origin, its history, its constitution or least of all its membership, a public body" and had "not been woven into any system of governmental control of horseracing so successfully that there has been no need for any such governmental system and such does not therefore exist" (Lord Bingham MR at p.923G-H). Similarly, "[h]owever impressive its powers may be, the Jockey Club operates entirely in the private sector and its activities are governed by private law (Hoffman LJ at p.931-A). The Court also considered whether the Claimant had a private law remedy available to him. Hoffmann LJ noted that the Claimant could obtain a declaration that the Jockey Club's decision was ineffective and if necessary, an injunction to restrain the Club from implementing it. He therefore concluded at p.933G that no injustice was likely to be caused to the Claimant by the denial of a public law remedy.

46. In *Poplar Housing and Regeneration Community Association Ltd v Donoghue* [2002] QB 48, the Court had to consider whether a housing association was a public authority or performing a public function within the meaning of section 6 of the Human Rights Act 1998 (HRA). It is recognised that there is considerable overlap between this issue and the question of amenability to judicial review (see, for example, *R (Beer) v Hampshire Farmers Market Limited* [2004] 1 WLR 233 at [29] in which the Court of Appeal observed that "on the facts of most cases the two issues march hand in hand: the answer to one provides the answer to the

other"). In *Poplar Housing* at [65], Lord Woolf stated that "the more closely the acts that could be of a private nature are enmeshed in the activities of a public body the more likely they are to be public".

47. In *Beer*, the Court of Appeal emphasised that "there is no simple litmus test of amenability to judicial review". Dyson LJ, giving the judgment of the court, stated at [16] that:

> "It seems to me that the law has now been developed to the point where, unless the source of power clearly provides the answer, the question whether the decision of a body is amenable judicial review requires a careful consideration of the nature of the power and function that has been exercised to see whether the decision has a sufficient public law element, flavour or character to bring it within the purview of public law. It may be said with some justification that this criterion for amenability is very broad, not to say question-begging. But it provides the framework for the investigation that has to be conducted."

48. *YL v Birmingham City Council* [2007] UKHL 27, [2008] 1 AC 95 remains the leading case on the concept of functions of a public nature under the HRA. The House of Lords held that a private care home providing accommodation and care to residents who were placed there by a local authority pursuant to its statutory duties and powers, and whose accommodation and care were paid for by that local authority, was not exercising public functions.

49. The RCS distilled the following relevant factors from the majority judgments in *YL*: (i) whether the function is of an inherently governmental nature and the extent to which the body is "taking the place" of central or local government; (ii) whether the body enjoys any special statutory powers or duties, especially powers of compulsion; (iii) whether the body is democratically accountable; (iv) whether the body is providing a public service and is under a duty to act only in the public interest, as distinct from a private person carrying out activities pursuant to private law contractual obligations and for private and commercial motives (even if those activities are in the public interest or for the public benefit); (v) whether public funding supports or subsidises (in whole or in part) the cost of the body carrying out the service as a whole, for example by way of an injection of capital or subsidy into an organisation in return for undertaking a non-commercial role or activity of general public interest, as distinct from a public authority paying the body for the provision of the service to a specific person; and (vi) the reason why a person is carrying out activities, hence a local authority running a care home is doing so pursuant to public law obligations whereas a private person is doing so pursuant to private law contractual obligations (Lord Scott at [26]-[28] and [31], Lord Mance at [102]-[105] and [115], Lord Neuberger at [135], [148], [150], [159] and [164]-[167]).

50. In *R (Ames) v Lord Chancellor* [2018] EWHC 2250 (Admin) at [55] Holroyde LJ and Green J reiterated that if a decision does not have a sufficient public law element to make it amenable to judicial review, the fact that the aggrieved party has no other avenue of appeal is not a reason for treating the decision as if it were a public law decision.

51. In *R (Hannah) v The Chartered Institute of Taxation* [2021] EWHC 1069 (Admin) at [44], Holgate J said the following:

> "If the source of power is legislation, then their body in question will generally be subject to review. If at the other end of the scale the source of power is purely contractual, as for example in the case of a private arbitration, judicial

> review is not available. In the area between these two poles, it is relevant to look not only at the source of the power but also its nature to see whether the body is exercising public law functions or whether the exercise of its functions has public law or consequences. The essential distinction is between on the one hand, a purely domestic or private tribunal and on the other a body, which is under a public duty".

52. The RCS provided a series of examples of cases in which the courts have rejected attempts to characterise private bodies as being "woven into the fabric of public regulation" so as to render them amenable to review. It was submitted that these cases showed that the following features do not result in a body being amenable to review:

    (i) Formal recognition of a body under a statutory scheme as being part of a self-regulatory regime (*R v Insurance Ombudsman Bureau, ex parte Aegon Life Assurance Ltd* [1994] CLC 88 and "*R (The Underwritten Warranty Co Ltd (t/a The Insurance Backed Guarantee CO)) v FENSA Ltd* [2017] EWHC 2308 (Admin)"

    (ii) Formal recognition of a body under a statutory scheme as providing arrangements that will enable the body's members to meet their regulatory obligations: (*R (Sunspell Ltd) v Association of British Travel Agents* [2001] ACD 16);

    (iii) Provision of a voluntary arbitration service to resolve complaints against regulated persons (*R (Mooyer) v Personal Investment Authority Ombudsman Bureau Limited* [2001] EWHC 247 (Admin));

    (iv) A body being established by an Act of Parliament and adjudicating on disputes between contracting parties (*R (West) v Lloyd's of London* [2004] EWCA Civ 506, [2004] 3 All ER 251);

    (v) A body being established by Royal Charter and setting up a disciplinary board to adjudicate on complaints about its members (*R (Hannah) v Chartered Institute of Taxation* [2021] EWHC 1069 (Admin)); and

    (vi) A defence organisation's indemnity benefits being recognised by a healthcare regulator as providing one way in which dentists could meet certain professional obligations, as an alternative to having an indemnity from an insurance company (*R (Moreton) v Medical Defence Union Ltd* [2006] EWHC 1948 (Admin))).

The parties' submissions

The Claimant's case

53. The Claimant submitted that in carrying out its IRM function, the RCS is a body exercising a public function. The IRM can only be initiated by a formal request by a healthcare organisation. The Claimant asserted that this in practice is almost exclusively a public healthcare organisation. The RCS reserves the right to refer to regulators and has given an unequivocal commitment to do if there are concerns that the commissioning organisation will not. The Handbook describes the IRM function in public law terms, such as the commitment to act in an open, fair and structured way. As the facts of this case illustrate, an IRM can take place without the consent of the doctor in question. He argued that these factors give the IRM

a "sufficient public law element, flavour or character to bring it within the purview of public law" (per Dyson LJ in *Beer*).

54. Further, he argued that the Court should not be misled by the "invited" and "voluntary" elements of the IRM: in reality, it is "woven into the fabric of public regulation" (per Lord Bingham in *Datafin*) and "enmeshed in the activities of a public body" (per Lord Woolf in *Poplar Housing*). He conceptualised the IRM as "a diagnostic intervention commissioned by a Trust, under a memorandum of understanding with the PPA (a regulator) and as a precursor to further intervention by the Trust, GMC or CQC (all public bodies which exercise a regulatory function in respect of doctors) and may prompt any relevant Health Safety alert that may be necessary or other action to protect patients – eg a restriction on practice". He submitted that the PPA is amenable to judicial review.

55. The Claimant took issue with RCS's characterisation of the IRM as "purely advisory" or one where no decision or decision of any effect was taken. Rather, there was a clear recommendation that patient safety action including referral to the GMC and disclosure to patients needed to be taken by the Trust. The Claimant argued that on receipt of a recommendation to contact the GMC ELA, the Trust would have known that it had no choice but to contact the GMC, because if it did not do so within a reasonable timeframe then the RCS would do so.

56. Noting Sir John Donaldson MR's reference in *Datafin* to the exclusion from the public law jurisdiction of bodies whose sole source of power is a consensual submission to its jurisdiction, the Claimant argued that there was no consensual submission to the CRR by him: he was not asked for his consent to it, was not told that the CRR was being undertaken and when he was informed it had been undertaken and a report on the findings and conclusions from the review was in process, was not invited to participate in any way prior to the report being submitted to the Trust.

57. The Claimant submitted that the IRM could not properly be classified as a "bolt on" to the employment relationship. The RCS's argument that as he would have no complaint if the IRM had been carried out by the Trust, this suggested that the RCS's IRM was not amenable to judicial review, was specious. The fact was that the IRM had been carried out externally, and it was specified as being outside MHPS. If the Trust had conducted the IRM, he would have had a remedy under his contract of employment. *West London Mental Health NHS Trust v Chhabra* [2013] UKSC 80 illustrates that injunctive and declaratory relief can be obtained where an MHPS investigation is carried out by an employer in breach of MHPS terms. However, as the RCS conducted the IRM, he has no effective remedy other than judicial review against the RCS: he cannot bring a contractual claim against the RCS as he is not party to the contract under which the IRM was performed and he has no effective contractual remedy against the Trust, which has relied on the RCS for its decision to restrict his practice under the MHPS.

58. The Claimant argued that he has no ability to challenge the content of the report or to prevent its wider dissemination or publication. His only ability to challenge its conclusions with the Trust is through the Trust's own investigation process, triggered by the IRM. However, this is a separate process. It has, as is often the case, been very protracted, only resulting in the report issued to him in February 2022. In the meantime, he has suffered significant disadvantage in that the restrictions on his day-to-day practice have been maintained, on the

basis that the IRM's conclusions are or may well be well-founded until the contrary is shown. This has had an obviously damaging impact on his reputation and career.

59. He drew support from *R v NHS Executive, ex parte Ingoldby* [1999] COD 167 in which Popplewell J granted the Claimant permission to seek judicial review of a similar report provided by an external clinical review panel under a predecessor scheme to the IRM. In granting permission, Popplewell J had regard to the Claimant's lack of any private law right of action against the Panel, save for defamation, which would not deal with the question of procedural impropriety if it was shown to exist. He also considered the unfairness to the Claimant if the report containing deficient conclusions was published or used against him for regulatory or disciplinary purposes. The Claimant accepted that this was only a permission decision, but argued that it was a reasoned decision, on strikingly similar facts.

60. The Claimant argued that the IRM has a function and significance in the regulatory system of much wider import than any internal investigation by the Trust. The analogy drawn by the RCS with *R (Holmcroft Properties Ltd) v KPMG LLP* [2018] EWCA Civ 2093, [2020] Bus LR 203 was therefore misplaced: in that case KPMG was contractually discharging a function that would otherwise have been performed by the bank in what was fundamentally a private law matter as between the Claimant and the bank. The IRM was also wholly different from cases such as *R v Insurance Ombudsman Bureau, ex parte Aegon Life Assurance Ltd* [1994] CLC 88 where scenarios akin to private law arbitrations were held to be outwith judicial review. These scenarios did not involve government functions but were entirely contractual and private in nature.

61. The Claimant submitted that the proposed statutory duty of co-operation regulations also indicated that the IRM should be subject to judicial review. He relied on the observations of Sir Clive Lewis in Judicial Remedies in Public Law (6th Edition) to the effect that "recognition that a particular function is governmental or has become suitable for legislation may be enough to render bodies actually performing that function susceptible to judicial review, even though the bodies are not set up by the government" (paragraph 2-086). The Claimant also drew support from the passages referring to the following sorts of decision being judicially reviewable: (i) non-statutory local authority decisions to include an individual on a register of suspected child abusers, given the *de facto* potential impact on the individual's employment prospects and relationship with the authority (paragraph 2-101); (ii) decisions affecting the ability of an individual to pursue a profession or trade or removing a person from office (paragraph 4-012); and (iii) recommendations made from one body to another if they have a legal significance, for example because they are a pre-condition of the exercise of a statutory power or must be taken into account by the receiving body (paragraph 4-027)

The RCS's case

62. The RCS relied on the voluntary and contractual nature of the IRM. It is for a healthcare organisation, whether in the public or private sector, and whether within the UK healthcare environment or outside it, to request an IRM. It is not the case that the IRM service is used almost exclusively by public organisations, as asserted by the claimant. The RCS can decline to carry out the review for a number of reasons. If an IRM takes place, the process is contractually determined by the conditions set out in the Handbook, the agreed terms of reference and the Deed of Indemnity. Consent of the relevant member of staff is required for an individual review but not for the other types of review.

63. It was "irrelevant and inapt" to describe the IRM process as "non-consensual". This principle derived from cases such as *Datafin* which concerned regulatory bodies which have the power to take action against those within their jurisdiction which did not apply here: the RCS was in no sense exercising power over the Claimant. The only relevant consent here was that of the commissioning healthcare organisation which plainly consents to the IRM, based on the contract. Individual reviews will also only proceed with the consent of the surgeon. By contrast, consent plays no role in a CRR which is a paper exercise, in principle requires no input from clinicians and can focus on the work of a range of clinicians.

64. The RCS submitted that the Claimant's conceptualisation of the IRM as set out at paragraph 54 above contained a number of fundamental errors and misconceptions that lay at the heart of the proceedings: (i) an IRM is not an "intervention" but a review, and nothing more; (ii) an IRM team simply provides advice which is intended to assist the commissioning healthcare organisation to deciding how it wishes to proceed in respect of the services it provides and the doctors it employs; its role is thus directly comparable to the role of KPMG in *Holmcroft* in assisting Barclays to resolve private law issues with its customers; (iii) to describe an IRM as a precursor to further intervention by the Trust, GMC or CQC is simply wrong: there is no presumption when an IRM commences that any such further action will follow and very often it does not; (iv) the PPA is not a regulator and has no role in authorising the commissioning of invited reviews, in undertaking such reviews or as part of the oversight process: the co-opted PPA representative on the Oversight Group has no involvement in individual cases or sight of any IRM reports before or after they are finalised.

65. Rather, the RCS in conducting IRMs is a private body offering purely advisory services to healthcare organisations, no different from any other expert providing advice for a fee. It does not have any power to take any decision having any substantive legal consequences for surgeons. It is for the commissioning healthcare organisation and all the relevant healthcare regulators to decide what if any action to take in respect of any matters on which the review team provides advice, and they are not bound by the review team's views on any issue.

66. The fact that the healthcare sector is regulated, involving public authorities such as NHS bodies and statutory regulators, does not mean that the RCS is itself performing a public function when carrying out an IRM. Neither does the fact that the RCS might (like any other private body or person) make public interest disclosures to regulators. The RCS' "reservation" of the right to disclose concerns to a regulator is firmly located in the context of the RCS having a purely advisory role. It is only if the healthcare organisation does not take appropriate action itself that the RCS would ever consider directly reporting matters to a regulator. In practice it will rarely, if ever, need to do so. In fact, making such disclosures is an aspect of the professional duties on all medical professionals. The position is therefore directly comparable to *Hannah*, in which Holgate J held that the Chartered Institute of Taxation's decision to refer a complaint to the disciplinary body was not amenable to judicial review. He relied on the fact that members of the public could make such complaints and they would not be amenable to judicial review. In this case, the IRM had not left the Trust with "no choice" but to refer the Claimant to the GMC: it had simply suggested that the Trust have a conversation with the GMC ELA, as a means of discussing whether a referral to the GMC was appropriate.

67. The same applies to the fact that the RCS might encourage a commissioning organisation to consider its own statutory duty of candour to patients: again, all the RCS can do is advise a

healthcare organisation to consider its own duty; the RCS has no such duty; and there is no question that it would take it upon itself to contact patients.

68. The RCS submitted that if the IRM had been carried out by the Trust's own staff, been outsourced to surgeons employed by a neighbouring trust, or indeed by the authors of the IRM on a direct contractual basis, it could not be argued that the IRM report would be reviewable. This indicates that the IRM is a purely private matter.

69. The absence of an alternative remedy is not in itself a reason for treating the IRM as a public law process (*Ames*). *Ingoldby* was wrongly decided and in any event distinguishable, as it related to the imminent publication to the world at large of the critical report. There was no suggestion that that was going to happen here. In any event, there are effective remedies available. The report can be remedied via complaint to the commissioning organisation as the owner of the report (albeit that there is no real need to do so, as the report itself decides nothing). If the healthcare organisation decides to act on the report, the surgeon has ample opportunity within the organisation's own procedures, and/or the GMC's, to challenge the views expressed in the report. If the surgeon considers the healthcare organisation or the GMC is acting unlawfully, the surgeon has the ability to bring a contractual claim against the organisation and/or judicial review proceedings against the GMC. Indeed, the Claimant is bringing separate High Court proceedings against the Trust, focussing on the delay the Trust's own processes are taking. The RCS position was that these proceedings "will precisely address the injustice which he claims he will suffer if he is not able to seek judicial review of the RCS report".

70. The fact that the Handbook indicates that IRMs would be carried out in an open, fair and structured way and such similar sentiments were nothing more than statements of what would be expected of any professional person offering to provide expert advice. They did not indicate that the IRM was a public function.

71. Overall, applying the two-limb test summarised by Dyson LJ in *Beer*, the RCS submitted that (i) the source of the IRM function, namely contractual arrangements between the RCS and healthcare organisations, does not indicate that judicial review would apply, not least because the RCS is under no obligation, whether statutory or otherwise, to offer the IRM service and because other private individuals and bodies are frequently commissioned to provide such a service; and (ii) there is no sufficient public element, flavour or character to bring the IRM within the purview of public law.

72. Similarly, applying the factors identified by the House of Lords in *YL*, (i) no aspect of the RCS's invited review service is governmental in nature; (ii) the RCS does not enjoy any special statutory powers or duties; (iii) the RCS is not democratically accountable in any sense; (iv) the RCS is not providing a public service, nor is it under a duty to act only in the public interest; and (v) the RCS is not supported or subsidised by public funding.

73. Finally, the RCS expressed concern about the "chilling effect" of a decision that the IRM is amenable to judicial review. Professor Rockall's evidence was that such a decision could lead to healthcare organisations avoiding using the IRM service provided by the RCS and other Colleges, or using less suitable providers to perform the service, and ultimately increasing the risk to patients.

Analysis

74. The most concise distillation of the approach to be applied to determine whether a particular power is amenable to judicial review remains the Court of Appeal's analysis in *Beer* at [16], given by Dyson LJ. This requires consideration of (i) the source of the power in question; and (ii) if that does not provides the answer, an analysis of the nature of the power and function that has been exercised to see whether the decision has a sufficient "public law element, flavour or character" to bring it within the purview of public law.

(i) The source of the power to conduct an IRM

75. The source of the power to conduct an IRM is not legislative. I draw limited assistance from the Claimant's argument that at one point the government was considering regulations about information-sharing in the healthcare sector. This is quite different to proposed legislation to govern the IRM process. Information-sharing might be part of, or the result of, an IRM process, but the two things are not identical. I do not therefore consider that these proposed regulations involve a recognition that the IRM function has become suitable for legislation as the Claimant suggested.

76. The source of the power not being legislative, per Holgate J in *Hannah*, it is necessary to consider whether it is "purely contractual" such that judicial review is not available, or somewhere in the "area between these two poles" such that the nature of the power is important.

77. The source of the power to conduct an IRM is the contract between the RCS and the commissioning healthcare organisation. Both those parties need to agree to the IRM being carried out in return for a fee and comply with the other terms required. To that extent the source of the power is purely contractual. The RCS is under no obligation to offer IRMs, and healthcare organisations are under no obligation to commission them. To that extent the source of the power is also entirely voluntary.

78. However it does seem to me relevant that although they are not parties to the contract, surgeons can ultimately be adversely affected by the consequences of an IRM, and may not have consented to it if, as here, it is the CRR type of IRM.

79. I therefore consider that while the contractual, and largely consensual, source of the power to conduct an IRM is a persuasive factor in support of the proposition that the IRM is not amenable to judicial review, this factor alone is not sufficient to resolve the amenability question. In fairness, the RCS did not argue that it did. It is therefore necessary to move to the second stage of the *Beer* analysis.

(ii) The nature of the power and function and sufficiency of "public law element, flavour or character"

80. There is no doubt that IRMs which are critical of individual surgeons, like the CRR here, are likely to lead to adverse personal consequences for that surgeon, as they have here. It is consistent with the expertise involved in the IRM and the tenor of the Handbook that commissioning organisations are likely to follow the recommendations of an IRM, albeit that they are not required to do so. Specifically, it is likely that any recommendation of contact with the GMC will be followed, again even if they are not required to do so.

81. However, the fact remains that IRMs are, strictly and formally, advisory. They do not lead, in themselves, to direct consequences for surgeons. This makes IRMs different to the scenarios addressing the consequences to individuals considered by Lord Diplock in *Council of Civil Service Unions*; and different to the decisions by an employer or a regulator which directly adversely the individual's ability to work, examples of which were cited at Lewis, paragraph 4-012.

82. The IRM process makes recommendations, but ultimately it is for the commissioning healthcare organisation to decide what to do in response to them. They are of a different nature to the examples of recommendations cited in Lewis at paragraph 4-027: there is no legal requirement that they are taken into account by the commissioning healthcare organisation and they are not pre-conditions to the exercise of a statutory power, for example.

83. I consider it fair to classify the IRM as akin to an extension of the employment relationship. The employer can choose to use an IRM to obtain views about a surgeon's work and can then decide to act on the contents of the IRM. Judicial review is generally not available in relation to employment matters.

84. In my view the fact that after an IRM the RCS could refer matters to the GMC or another regulator if the commissioning healthcare organisation did not do so is not sufficient to render this a public function: referring matters to a regulator is something private individuals can do, without any suggestion that such referrals should be amenable to judicial review. The "reservation" of the right to refer to regulators which underpins the IRM is therefore comparable to the Chartered Institute of Taxation's ability to refer a complaint to the disciplinary body in *Hannah*, which Holgate J held was outside the scope of judicial review.

85. Therefore, although the IRM can form an element of the regulatory process, in that it can lead to a referral by the healthcare organisation or by the RCS itself, I do not consider that this illustrates that it has been "woven into the fabric of public regulation".

86. The fact that the RCS might encourage a commissioning organisation to consider its statutory duty of candour to patients is even less persuasive, because if the commissioning organisation declines to do so, there is no suggestion that the RCS will act.

87. I accept the RCS's submission that the indications in the Handbook as to how the IRM process will be carried out do nothing more than evidence expected good practice in professionally carried out reviews. They do not indicate a public law element.

88. The fact that the IRM function could have been carried out by private individuals or a private supplier organisation, without any real ability to suggest that such a function should be amenable to judicial review, is a further indicator that the IRM is a largely private matter. The same applies to the fact that the IRM could be commissioned by a private healthcare provider as well as a public one.

89. For these reasons, applying Lord Woolf's phrase in *Poplar Housing* at [65], an IRM is not so "closely enmeshed in the activities of a public body" that it should be considered a public function. It is also pertinent that the various factors identified by the House of Lords in *YL* point away from the IRM being amenable to judicial review, as the RCS's analysis showed.

90. Overall, therefore, having considered the nature of the power and function, I do not consider that the IRM process itself has a sufficient public law element, flavour or character to render it amenable to judicial review.

91. Thus, applying *Ames* at [55], the fact that the Claimant does not have a direct remedy against the RCS to challenge the procedure followed or the contents of the report is not in itself a reason for treating the IRM process as if it were a public function. It is also relevant that the Claimant is not entirely without remedy: he was able to request, through the Trust process, revisions to the IRM report; he has brought civil proceedings against the Trust relating to the actions it took after the IRM; and if the GMC later acts against him in a way which he considers to be unlawful, he can bring judicial review proceedings against the GMC.

92. I readily accept that, as the facts of this case illustrate, a surgeon can perceive the IRM as having a significant amount of potential power, as the Panel on Takeovers and Mergers was considered to have in *Datafin.* It is also the case that absent the right to bring judicial review proceedings against the RCS, a surgeon in the Claimant's position does not have a direct remedy against the RCS to remedy what are said to be failings in the IRM procedure or the content of the report, or to prevent the report's dissemination. To that limited extent, the case is similar to *Ingoldby*.

93. On balance, however, I am not persuaded that these factors are sufficient to outweigh the factors pointing away from the IRM being amenable to judicial review.

94. I was not persuaded by the "chilling effect" argument advanced by the RCS. The RCS has chosen to offer the IRM service. If in fact the IRM was amenable to judicial review, it would be open to the RCS to conclude that it has nothing to fear from judicial review and to continue to offer the service, or to decide not to do so. However those are not key considerations here. Ultimately I have reached this decision based on the *Beer* test and the principles that have emerged from the other cases summarised above.

Conclusion

95. For all these reasons I determine the preliminary issue to the effect that the IRM process is not amenable to judicial review. The Claimant's claim is therefore dismissed.