HSSA
H Smith Safety Associates

LESSONS LEARNED
External Review of the Trust's Response to the Management of a Consultant with a Criminal Conviction
May 2024

Commissioned by Royal Devon University Healthcare NHS Foundation Trust

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WARNING: THIS REPORT CONTAINS DESCRIPTIONS OF A SEXUAL NATURE THAT SOME PEOPLE MAY FIND DISTRESSING

Executive Summary

In February 2024 a senior consultant employed by the Royal Devon University Healthcare NHS Foundation Trust (RDUH) was found guilty of three offences; making and possessing indecent images of children (three counts), possession of prohibited images of child pornographic or grossly offensive, disgusting or of an obscene character and possession of extreme pornographic images. This event sent shockwaves through the department they worked in, more broadly across the RDUH and into the population served by the hospital. This event came to light through the courage of a member of staff, who spoke up when they saw something wrong, the actions of staff and the systems in place that contained this situation. The RDUH team worked closely with the Police and other statutory agencies to enable the investigation and bring these events to their final conclusion. These events must be separated from the clinical care that the doctor delivered, the quality of which has never been in question.

No one in the RDUH is to blame for what has happened. The responsibility for the actions lies solely with the doctor. The RDUH has commissioned this review, using the principles laid out in a Just and Restorative Culture, to understand the impact this has had on the RDUH and to determine any learning that can be taken from these events. The principles of a Just and Restorative Culture provide the framework for gaining a clear understanding of what has happened, to understand what harm has been caused and where improvements could be made. Consideration is also given to the impact of hindsight bias; it is easy to see where people went wrong, what they should have done or avoided doing when an outcome is known. This approach helps to create the culture that supports improvements to take place.

Many people have shared their stories of working with the doctor. People have been generous with their time and with their candour during this review. On numerous occasions people became visibly distressed when describing their experiences. People have shared feelings of anger, of guilt and of shame. Professional relationships have been compromised and trust broken. However, every professional group describes each other with respect, despite their differences of opinion and the concerns raised.

The review concludes with a number of areas where the RDUH could consider improving its systems and process. In most areas there are improvements already underway and the findings in this review could add to them. The review recognises the importance of ensuring the culture of the RDUH in creating conditions where people can speak up and be heard, and for everyone, particularly (but not solely) women, to feel sexually safe at work. The review also offered some opportunity to continue the work that is being done to improve the support for managing doctors well in the RDUH. In particular, the storage and sharing of information, escalation processes and the importance of diverse expertise when managing complex situations are areas for focus. Finally, there is opportunity to improve the process of communication within the RDUH in situations involving confidentiality, safety and where staff are impacted by external events.

The RDUH has already started the process to repair itself after the events that have taken place. This review is part of the restorative approach that the RDUH is taking in response to the events which led to the conviction and sentencing of the doctor. Rebuilding relationships

and trust are fundamental to ensuring that teams can work together at their best and it is important for this work to continue.

It is important to note that there is no evidence that any of the images described in this review were taken on RDUH premises and this was confirmed by the Police using geo location technology.

Introduction

This report has been commissioned by the RDUH to undertake a review into issues and challenges which have arisen from an investigation into a case involving a criminal conviction for sexual offending involving children by an anaesthetic consultant employed within the RDUH, the doctor. The RDUH is keen to understand the period from the previous conviction of the doctor in France in 2017 leading to the date that the doctor was dismissed from the Trust on grounds of ill health, to understand what has happened, what damage has been caused and where improvements need to be made.

The review focuses on four specific incidents:

a. Inappropriate taking of images in France, 2017
b. Drug misappropriation at RDUH, 2019
c. Inappropriate comment made to a female colleague, 2020
d. Viewing of an image by subject on their mobile phone whilst working in theatres at RDUH, 2022

To complete this review more than 30 individuals have shared their accounts and more than 25 hours have been spent listening and talking to people about this review. Those who have participated have come from many backgrounds: operating department practitioners (ODP), nurses, human resource professionals (HR), departmental management, and consultants, including consultants in management roles and colleagues from this department and from other specialities. It was not possible to speak to the doctor following the conviction in March 2024, nor to those close to the doctor who are not employed by the RDUH. It is important to note that their perspectives are missing from this review. I have had access to the human resources (HR) files and more than 450 emails, with attachments, containing information about the doctor from medical managers' (past and present) storage systems. (See ***Appendix A*** – Dr Helen Smith).

I was also given access to:

1. RDUH Maintaining High Professional Standards Policy
2. RDUH Promoting a Positive Working Environment Policy
3. RDUH Our Charter
4. RDUH Management of Allegations Policy
5. RDUH Attendance Management Policy and Procedure
6. RDUH Managing Performance (Capability) Policy

I have been asked to review the RDUH's responses to the incidents described above in relation to legislation, regulatory requirement and RDUH Policies and Procedures and consider if:

1. correct policy and procedure were applied,
2. GMC involvement was timely and appropriate,
3. appropriate arrangements were made to support the subject's health and well-being,

4. decisions taken in relation to the subject's return to work and management of their work were appropriate and adequate,
5. adequate governance arrangements supporting their return to work were in place,
6. the correct reporting was undertaken,
7. the subject's behaviour was considered over time,
8. the timeliness of management of the final incident within the RDUH was appropriate,
9. the management of the subject's ill health retirement was managed in line with legislation, and was fair and appropriate.

This review focuses on the experiences of the people involved and the policies and processes that guided their work.

The review concludes at the point that the subject was dismissed on the grounds of ill health.

(See Terms of Reference ***Appendix B***)

Review Approach

This is a very unusual case. It is rare for those working within a healthcare system to manage a doctor with this level of complexity for whom mental health and criminal behaviour co-exist. This review involves a doctor who was held in high professional regard by all of those who worked with them - no concerns were raised about their technical ability. The doctor was a senior member of the department and had held a number of senior management roles within their department and within the clinical governance system over a number of years.

This review focuses on this doctor's behaviours in the setting in which they worked and covers four main events that occurred over a span of more than six years. The RDUH has not remained static over this time period either in its functioning or its context and the RDUH has been improving many of its systems over this time period. The Covid pandemic has impacted the delivery of care within our healthcare system. The anaesthetic department was not immune to any of this.

It is easy to see how decisions may have been taken differently when the eventual outcome is known. It is important to ensure each of the decisions taken were considered in light of the evidence available at the time and with consideration of hindsight bias.

The review is carried out using the principles of Just and Restorative Culture. This approach concentrates on the system and process that supports people working together to do their jobs. When things go wrong, errors are made, or practice violates away from an expected norm, it is important that any review is undertaken in a manner, and with a structure, that creates the best conditions for understanding what has happened, identifies any possible areas for improvement and supports a positive culture for learning.

The events described in this review have led to harm to people who work in the RDUH and to the Trust itself. This harm needs to be understood so that healing can continue and the RDUH, and those who work there, can feel safe to do their complex work and continue to provide their best care.

This approach allows for collection of multiple different accounts from different stakeholders, ensuring that the situations that arise are understood as fully as possible. Practice is checked against policy and procedure, and an understanding of any deviation from this sought.

Principles of Just Culture

a. **Do not ask 'who' is responsible but 'what' is responsible**

   Human factors research shows that people's assessments and actions make sense once we understand the critical features of the world in which they work in.

b. **People do not come to work to do a bad job**

   People come to work to get the job done, they do not come to work to break rules or purposefully cause harm. Indeed, when things do go wrong, it is the people who were

involved who feel the most responsibility and accountability for the action taken, often to their own personal detriment. It is important that the response to any harm caused is not to create further harm.

c. Understand the difference when 'work as imagined' and 'work as takes place'

In 'work as imagined' people never make mistakes, they do not forget, things are always done right. This is not reality, and the further away people are from where and when the work was done the less accurately it is imagined. 'Work as done' is what actually matters. This is influenced by the real world of shifting demands, environmental, psychological, and cognitive factors. People are too often judged by those who do not understand the work they do. They do not know the 'messy' detail and they often lack the technical knowledge and misunderstand the subtleties of what it is like to work in the area of the health system concerned.

d. Taking the principles of a restorative rather than retributive approach to justice

When errors happen in which harm is caused, a retributive approach answers harm with harm, blame and sanction causing further harm to those perceived to be at fault. A restorative approach focuses on healing, understanding who has been harmed in a much broader sense, what they need and who should be obliged to meet this need. Restorative justice fosters a dialogue between individuals and communities involved that rebuilds relationships and trust, rather than a breakdown in relationships through sanction and punishment.

e. Employing forward rather than backward accountability

Backward accountability seeks to hold people accountable (to blame and to put sanctions in place) for what has happened. This changes nothing about the harm that has happened. There is a popular misconception that when people experience a retributive response that this improves safety. The logic flows that sanctions imposed will make sure people will know better next time and safety will improve. However, there is a consequence to this approach which tends to create fear, and it is this fear that inhibits people from speaking up in the future. If people do not feel able to speak up candidly, without fear, the working of an organisation becomes opaque and less safe as a result. Forward accountability creates the opportunity for all of those involved to share their accounts, for the situations where errors occur to be more fully understood and for learning to be created. Individuals involved can take accountability for making improvements and reducing the risk of future harm.

f. Understand who the second victims are, hear their accounts and support them well

Second victims are people who have been indirectly involved in incidents that have occurred. This can be a broad group of people. It may be the RDUH itself, or members of staff or other patients who were present when the incidents happen. The opportunity to recount the experiences first hand can be healing, if taken seriously and not linked to retribution. The lived experience of second victims represents a treasure trove of

information about how safety is made and broken at the very heart of an organisation. Strong organisational and social systems have proven critical to containing the negative consequences of safety incidents.

The importance of Hindsight Bias

- "*There is almost no human action/decision that cannot be made to look flawed and less sensible in the misleading light of hindsight. It is essential that the critic should keep himself constantly aware of the fact*."

Sir Anthony Hidden
Clapham Junction Accident

Knowing the outcome of an error(s) or series of events has a profound effect on those reviewing them.

a. It becomes easy to see where people went wrong, what they should have done or have avoided doing.
b. It becomes easy to see omissions or how harm could have been avoided.
c. It leads to:
    - oversimplifying the cause of the outcome when working backwards from it,
    - overestimating the likelihood of the outcome,
    - overrating the role of procedure/rule violations (nearly always a gap that almost never causes harm),
    - misjudging the prominence of the data at the time,
    - a worse outcome the more culpable the mistake,
    - a bad outcome equals bad actions.

No one could have predicted the final outcome of this trail of events and this review does not seek to suggest that the final outcome was preventable. The report concludes with a number of areas for improvement and is a systems-based review. As such many of the areas for improvement interconnect.

Method

Most of this work took place in March and April 2024. During this time more than 30 people were interviewed, some in groups and some as individuals. Some individuals were approached (because of their prominent role in managing these events) and some approached the review team because they had information that they wanted to share. I spoke to many consultant medical staff, some who worked within the medical management structure, some who also trained in the department and some who were colleagues or who worked in other specialities. I spoke to staff who worked in non-clinical teams involved in these events and I spoke with other clinical members of teams who worked within the multidisciplinary teams in the operating theatres.

Everyone I met spoke willingly and openly with me. People were very generous with their time, and, for some, this meant recalling events that were personally distressing for them.

People were keen to share their stories and were thoughtful in their consideration of how things may be done differently in the future. I would like to sincerely offer my thanks to everyone I spoke with.

Reviewing Each Incident

a. Inappropriate taking of Images in France, 2017

This series of events started in July 2017, when the doctor was arrested in France whilst on leave. There is limited official information about the charges, bar the notification of the final conviction from the French legal authorities in November 2017. By the doctor's own account, they were originally arrested for voyeurism. There are a number of accounts of this in different places, but it appears that on 12 separate occasions between 22 to 24 July the doctor took video footage of people using the shower cubicles next to them. (See ***Appendix C*** – timeline). The final conviction was for the lesser offence of an 'invasion of privacy' which, unlike voyeurism does not require an element of sexual motivation. There is no additional formal information about this, or the evidence that was used, or the court's deliberations.

On returning from leave, the doctor met with and informed the Executive Medical Director (MD) of their actions. The doctor said that they had entered a guilty plea and that a court date had been set for November 2017. The doctor also said that they had been diagnosed with a mental illness and that they had been signed off by their GP and would be taking sick leave. The doctor made a self-referral to the General Medical Council (GMC), the medical regulator. As per the Maintaining High Professional Standards (MHPS) policy a number of actions were taken. These were undertaken in a timely manner. Contact was made with the local GMC Employment Liaison Officer (ELA) and the National Clinical Advisory Service (NCAS).

Actions were put in place by the RDUH to provide the doctor with personal support and advice about where additional support may be sought. The doctor was advised to make an occupational health (OH) appointment. As the doctor was on sick leave there were no safeguarding issues that needed immediate management within the hospital. The current MHPS policy does state that "*Where an investigation establishes a suspected criminal action in the UK or abroad, this will be reported to the Police. The RDUH will consult the Police to ascertain the appropriateness of continuing with an investigation (under either its Conduct or Capability Procedure)*". There is no record of this taking place. The RDUH did seek legal advice during this process which is described later in this report.

In September 2017, a GMC interim panel met and placed conditions on the doctor's registration (1 September 2017 to 31 August 2018).

In January 2018, whilst the doctor remained on sick leave, the Executive MD received a report from the consultant psychiatrist responsible for treating the doctor. This report stated that the doctor had a mental illness. This illness had been successfully treated and by December 2017 they were symptom free. The doctor was also described as having a good understanding of the early warning signs of a relapse of this illness.

In March 2018, whilst the doctor was still on sick leave, the Executive MD met with NCAS to discuss the case. At this point the RDUH was aware that the doctor had been convicted, but had no further detail. They were also aware that the GMC were conducting their own investigation (hence why the RDUH had not conducted their own internal process), but the outcome of this investigation would not be known for a few months. A discussion took place

within the RDUH about the logistics of the doctor becoming well enough to return to work before the GMC investigation had been completed.

The Executive MD met with the doctor in April 2018 who confirmed that the case had been concluded in the French courts and that they had been convicted of an offence of 'invasion of privacy'. The RDUH asked that the doctor confirm this by obtaining a copy of the conviction statement as per RDUH's Disclosure and Barring Service Policy. This was duly received and stated that the conviction was for "violation of privacy by attachment, download or transfer of an image of a person of a sexual nature for acts committed in Daglan on 22 July to 24 July 2017". The doctor was fined 8127 euros (approx. £7000).

The nature of this conviction and the fact that it was committed in France are likely to have had a significant impact on how this doctor was managed from this point by regulators and the RDUH.

The RDUH sought legal advice about the conviction. As described the initial charge appears to have been voyeurism however the final conviction was one of an invasion of privacy. There is no legal equivalent in the UK. The closest offence is one of voyeurism, however this requires an element of sexual motivation, and this element was not required for the French conviction. The doctor always denied the element of sexual motivation, stating that the motivation for this behaviour was as a result of their mental health problem.

Legal advice about the acts carried out by the doctor raised the question, 'what was the purpose of observing the complainant and making a recording of them carrying out a private act?' In the UK, if a question arose about the motivation in a similar case, the determination would be made by a jury. It is a very important point in a case which could have resulted in a very different outcome for the doctor and their fitness to practice. Voyeurism is a criminal act under section 67 of the Sexual Offence's Act 2003. A conviction in the UK would mean that offenders would likely be considered for inclusion on the sex offender register. Inclusion on such a register impacts on a doctor's medical registration, their contact with vulnerable people and therefore upon their employment. Under this same act, a UK resident can be guilty of certain sexual offences if they have performed an act outside the UK which would constitute an offence in the UK. However, this provision would not cover a conviction in France for voyeurism.

In March 2018, the RDUH was made aware of the doctor's legal team argument surrounding their client's impairment to their fitness to practice. They had access to four psychiatric reports that had been commissioned and completed in preparation for the hearing. This legal argument included an assertion that the conviction was not a sexual crime and summarised that mental health was the causal factor in the doctor's conviction. Three of the reports supported this, the fourth did not.

In April, the GMC confirmed that the doctor had been referred to the Medical Practitioners Tribunal Service (MPTS) and that impairments to this doctor's practice would be considered in the area of their conviction. The GMC also confirmed that the doctor continued to have a licence to practice but with restrictions.

In April 2018, the RDUH completed an exclusion risk assessment. This concluded that the doctor may be able to return to work and that any risk posed could be managed if a number of conditions were met. The HR team recommended the RDUH develop an advanced care plan and, over a number of weeks, this was designed and agreed with all the relevant external agencies and the doctor. The purpose of the plan was to support the doctor to return safely to work, and to define their scope of practice. This plan detailed and focused specifically on this doctor's mental health and well-being. It had no mention of the behaviours that had resulted in the doctor's initial conviction.

Correspondence between RDUH and the doctor, dated 6 July 2018, confirmed an agreement that they could return to work. The doctor started a phased return to work on 16 July 2018. This involved undertaking clinical work only, with no on-call responsibility. The nature of the clinical work was also planned. The plan also included a meeting with one of five of the most senior anaesthetists in the department each morning prior to starting work. The purpose of these meetings was to assure colleagues that the doctor was not experiencing any of the symptoms/early warning signs of their mental illness.

The MPTS met to consider this case between 13 to 16 August 2018, early in the doctor's return to work process. The findings were that the doctor's fitness to practice was impaired in relation to his mental health, but not in relation to his conviction. Four psychiatrists gave opinions, three stating that the behaviour the doctor exhibited was not sexually motivated but related to the doctor's mental health problem. The fourth psychiatrist did not report the link between the doctor's state of mind and his conduct underlying the conviction and the tribunal dismissed this evidence. The RDUH did not have a copy of this fourth report and the only reference to this was as part of the record of determinations of the MPTS hearing. A copy of this determination was held in one of the medical manager's filing system. The doctor's fitness to practice was restricted from 18 September 2018 and was due for review on 17 March 2020.

These findings shaped the ongoing management of the doctor. Given the tribunals dismissal of the evidence in this fourth report it is easy to understand why the RDUH did not consider this fourth opinion any further. This judgement impacted on the management team, suggesting that supporting this doctor to manage their mental health was the most important consideration. Managers were clearly concerned about the doctor's risk of suicide. Linking of the behaviour of the doctor to a deteriorated mental state gave a sense that a deteriorated mental state took all responsibility from the doctor to manage their own actions. This was further reinforced by the doctor's own description of themselves into a 'good' and a 'bad' person, depending on their mental health, and that these two states functioned as if different people. There was also a belief that the doctor had a good understanding of their mental health and was able to recognise when they were becoming unwell. A presumption was made that the doctor could and would take the necessary action to prevent it from deteriorating further and them becoming vulnerable to the behaviour described in the original conviction.

The doctor's return to work was complicated for numerous reasons. Many of the non-medical staff group had worked in the RDUH for many years and had previous experience of doctors who had been dismissed for issues they saw as similar to those present for the doctor. Some also had broader experience of not being heard when they had raised issues of sexual safety in their work environment. There was information publicly available about the doctor that meant that they had an awareness of the case in France. The Tribunal made its decision early

in this doctor's return to work. Staff recalled episodes of behaviour that had caused discomfort before this first conviction over the years they had worked with the doctor. There had been gossip about the use of pornography at home by the doctor, there were times when the doctor had made remarks that caused discomfort and were perceived as sexually inappropriate, and times when staff felt forced to come into physical contact with the doctor as they moved about within anaesthetic rooms. Some of the doctor's practice in the operating theatre were considered at the outer limits of normal, particularly their involvement in the positioning and preparation of female patients for surgery. With the benefit of hindsight people felt guilty about not speaking up about these or not speaking more loudly. Some staff had experienced previous trauma that resonated with these circumstances, and this directly impacted on their work and relationship with the doctor. Some consultants who had been trainees recalled incidents that had made them feel uncomfortable when working with this doctor. They also said that they felt that the culture at the time inhibited any thought of them raising a concern about this.

This combination of matters on public record, rumour and discomfort of directly observed behaviours meant that the doctor was not being brought back into a neutral environment. The situation was made worse when an article was published in the Sun in September 2018 about the doctor's conviction.

The RDUH made significant attempts to manage the doctor's confidentiality, involving only a small group of HR and medical managers in the case management. However, although there was some understanding as to why this needed to be so, staff experienced the process as secretive and excluding, and did not feel that the decisions being taken were fully informed. Some reported to the review that it did not result in the conditions of the doctor returning being as rigorous as had been intended. The doctor was excluded from working in certain specialty operating lists, but some staff told the review that they felt this was incomplete and inadequate.

The medical managers' management of this situation was heavily influenced by the result of the medical tribunal hearing and the fact that the outcome of the GMC process supported development of a return to work process for the doctor.

The RDUH determined that the doctor could return to work and the medical team within the anaesthetic department were tasked to enact this and as far as they were concerned this had to be done. There was ambivalence in the department about the doctor's return; many consultants did not think that they should return to work in light of their criminal conviction, but others felt strongly enough to make representation to the Executive MD to allow the doctor to come back. The anaesthetic management team had not experienced the problems that their non-medical colleagues described; these behaviours happened when other consultants were not present. Consultant anaesthetists practice alone within the operating team, and it is not unusual for them to go for days without seeing each other. The pandemic amplified this and the lack of shared meeting space outside of the operating theatre compounded this.

When staff started to raise concerns with medical managers, the medical managers did not have this context. For them the context was of a doctor whose conviction was a direct result of their mental illness and their regulatory body, the doctor's health reports, and the RDUH management had sanctioned the doctor returning to work. Their job was to get this done.

They expressed concerns that the issues were part of a 'witch hunt', and this contributed to them being unable to hear the concerns in the spirit they were intended.

There was a requirement for the doctor to be supervised as they returned to work and the medical managers determined that this supervision could only be carried out by a small number of very senior anaesthetic consultant colleagues. There was also a plan for a weekly meeting with their line manager for the first month. Senior consultants were supervising a senior colleague whose clinical competence had not been called into question. The wider group of consultants working in the department and within theatres were not made aware of this aspect of the plan, neither were other disciplines, nursing staff and ODPs, all of whom are key members of the multi-disciplinary team delivering care in an operating theatre environment. This was further complicated by the resource intensity of the support; senior anaesthetists were supervising at the expense of supporting their own lists. The department was already experiencing staffing pressures and medical managers described concerns about the resource they had to complete the work the department needed to get done. This process depleted resource further. People described the intensity of the supervision reducing fairly quickly over time.

Attempts were made to limit the doctor's practice in relation to the most vulnerable patients. The judgements, made in good faith within the anaesthetic leadership team, were not always in keeping with the wider teams on the ground and their view, which led to distress and concern of which the leadership team were initially unaware. An example was shared of the doctor coming to a list on their first day back. The surgeon was completely unaware of the doctor's difficulties. These difficulties were raised by a colleague who expressed concern that a doctor with such issues should be working in that adult theatre environment. The surgeon undertook an internet search and easily found publicly available additional information. They were immediately concerned about the doctor being with the patient group on that list and this impacted their practice on that day and future lists. The surgeon was angry that they had not be made aware of this, but also reflective that if they had been aware that a safer plan might have been put together.

What is clear is that the core team were very cognisant of the doctor's mental health and the risks of self-harm associated with this and the requirement that had been placed on them to get the doctor back to work. There was a dissonance between this understandable focus and the concerns of other members of the operating theatre teams. Each professional/person was trying to make sense of, and decisions, based upon the knowledge and information that they had available to them. This information was a mix of formal and informal information. The amount and content of this information was different between different people and different professional groups and led to those in medical leadership roles feeling as if that the doctor was being unfairly targeted. It also led to other professionals feeling unheard and concerned that having this doctor back at work was potentially compromising patient safety. Both positions are understandable given the contexts in which they occurred.

The doctor had practice privileges at the Exeter Nuffield Hospital. On finding out about the criminal conviction in France the Hospital suspended these privileges. Anaesthetists working in the Exeter Nuffield Hospital are supplied by a consortium made up solely of anaesthetists who are also employed by RDUH. This consortium met with the doctor who explained their situation. Whilst doctors expressed empathy for their mental health difficulties (which people

described as evident), those spoken to in this review were concerned about their perception that the doctor was not taking responsibility for their actions. They did not want to take any further risks with this doctor and excluded them from further practice. Their decision making was influenced by the knowledge of the conviction, they did not have awareness of the behaviours that non-medical staff and trainees had seen and experienced when they were not present. The hospital management team also decided that this doctor could no longer work at this hospital. Practice privileges were never reinstated (or requested by the doctor) at the Exeter Nuffield Hospital.

Over the next few months, the doctor continued to re-integrate back into the workplace. In May 2019 the doctor asked to be allowed to start undertaking work at the weekends. This had been agreed by the GMC and was agreed by the RDUH at the end of May 2019. The doctor's mental illness is described as being in remission at this time.

Over the course of trying to manage these events, HR and medical managers did not always feel that the Executive Team appreciated the complexity of the medical management problems for which they had responsibility. At the time this case was being managed it was one of a number of complex cases being heard. Staff involved with the management of complex medical management problems did not always feel the Executive staff gave enough attention or time to supporting them.

b. Misappropriation of Drugs June 2019

On 6 June 2019 a member of staff reported to their line manager that they had seen a vial of medication in the doctor's bag. This was immediately reported to the medical manager who contacted the doctor as they were leaving the hospital on the same day. The doctor was asked to return the medication on the following day. The ELA was contacted and the RDUH acted under the MHPS policy. At this time medical managers raised concerns about the doctor practising independently given their health related misconduct. An incident was raised later that month, however, actions to manage this had already commenced.

After discussion with the ELA and Practitioners Performance Advice (PPA) formerly known as NCAS, the doctor was restricted from undertaking any clinical practice. An exclusion risk assessment was completed prior to this restriction.

This was one of four events the medical managers corresponded with the doctor about. This correspondence was in the context of concerns about their mental health. The events described were:

(i) viewing a streaker in theatre on their mobile phone,
(ii) the removal of the vial of medication,
(iii) failure to communicate with payroll about an issue with their salary,
(iv) a breakdown in the relationship involving another health professional about a clinical matter.

The letter also recognised the positive continued contribution and acknowledged the doctor's experience of feeling they were being excessively scrutinised. This is the only reference

anywhere in the information made available to the review or that mentions the streaker incident. With hindsight, the lack of additional information and escalation of this event demonstrates the loss of focus on the behaviours that caused the doctor to come to attention in the first place.

Early on in these events medical managers most directly involved shared a number of different views and concerns about these events. There was concern about the doctor's mental health and how it might deteriorate as a result of a period of exclusion and the need to keep this prominent in the decisions made. There was concern about the plausibility of the doctor's explanation for the theft, and of the impact of losing a senior member of staff in a department that was already short-staffed. There was no discussion about risks of a sexual nature linking back to the original conviction for taking video images in France. The focus was predominately focused on the doctor's health and well-being. The doctor attended their GP and OH and self-referred to the GMC.

At the time of this event the doctor told their medical managers that they felt mentally well. They also had recent OH and GMC assessments that deemed them well, preceding the incident. The doctor had expressed concerns about the level of scrutiny and supervision they were experiencing. A person close to the doctor, outside work, also expressed concern about the stress that the doctor was experiencing, that they were not supportive of the doctor returning to weekend work and that consideration should be given for deployment to another site in the RDUH.

An RDUH OH report produced at the end of June described the doctor's health to be satisfactory and within normal limits. They were felt to be fit to be at work, however, would not return until they had had a specialist opinion.

An investigation under MHPS was initiated by the RDUH and completed in September 2019. This made mention of drugs previously taken by the doctor with the intention of harming themselves after the original incident in 2017. This information is not contained in the HR file contemporaneously with the original criminal incident or in any other correspondence made available to the review. The doctor rationalised their behaviour (taking the vial this time) by describing theft as common practice for people in the department and they cited a number of examples. They also described that the drug stolen was for use to manage a dental problem that they were having. This was plausible, but not in keeping with how this substance would normally be utilised. The doctor's practice of undertaking female catheterisation, was also raised. The number of these undertaken was considered to be on the outer limits of what would be considered normal practice for an anaesthetist. The reason given was plausible, in that it sped processes up in theatre, but they were asked to stop this practice going forward.

The MHPS investigation report was discussed with the appropriate outside agencies, and this resulted in a decision to proceed to a formal hearing under the MHPS policy. The doctor also identified that in retrospect that this might have been experiencing the re-emergence of their mental illness. At a similar time, medical managers raised concerns about the fragility of the doctor's mental health, and they ensured that the doctor had access to appropriate support.

The RDUH received communication from the doctor's BMA representative expressing disappointment in the RDUH's decision to move to a disciplinary meeting when there were clearly concerns about health issues.

Th BMA letter appears to have influenced the subsequent change in direction. Senior medical management used their discretion to avoid a formal disciplinary hearing and use a different form of resolution. They initially agreed a sanction that started as a 12-month written warning in October 2019, but after receiving a psychiatric report from the doctor's treating psychiatrist in January 2020, the sanction was changed to a first written warning to be kept on file for six months from 24 October 2019. HR raised concerns about the timing of the warning, stating that the start date should be the date that information about the doctor had been received and reviewed by the management team.

In correspondence concerning a meeting with the doctor after the initial decision, a medical manager described accepting the assertion that the doctor was mentally unwell, as the doctor had told them that in the psychiatrist's opinion, he was not in good mental health at the time and in fact, was so unwell that he did not appreciate what he was doing. However, the report the manager eventually received from the treating psychiatrist made no comment on the link between the doctor's mental health and any behaviour associated with it.

The GMC and PPA were aware of these processes.

There were concerns raised by medical managers about returning the doctor back to work. These included the doctor's lack of insight, not recognising that they were unwell at the time of the drug misappropriation event, and the practicalities of directly supervising a consultant in their workplace, particularly in the longer term. These concerns were raised with the PPA and advice received. The advice included seeking additional information, legal and clinical, and in light of this considering future employment, including adjustments, ill health retirement or terminating employment. PPA also suggested that consideration of commissioning an independent specialist report be made, ultimately this was not done.

A GMC Medical Practitioner Tribunal Panel sat on 20 February 2020 to review the drug misappropriation incident. This panel found the doctor to have continued impairment to their fitness to practice and imposed conditions for a further 12 months. The panel also made two changes to the doctor's conditions, removing the requirement for clinical supervision and the requirement to only work at the RDUH.

The GMC informed the RDUH that they would take no further action with regard to the misappropriation of drugs.

The GMC wrote to the RDUH on 31 March 2020 stating all the necessary arrangements were in place for the doctor to return to work. The doctor returned to work in April 2020. There is no further documentation of any of the concerns raised prior to the RDUH receiving the Medical Practitioners Panel Hearing of the GMC decision to take no further action. However, staff have described feeling concerned that the doctor was not taking concerns about their behaviour seriously. The doctor would say things that would not be considered appropriate and then say, "I should not have said that" or ask staff if they had been good today. These all added to their discomfort of working with the doctor.

c. Incident involving inappropriate sexual comment to a female colleague, 2020

The information available about this initially describes two incidents, one occurring at the end of October 2020, where a lewd comment was made to a female member of staff. This was felt by that member of staff to be uncalled for and made her feel uncomfortable.

The second, the one mentioned in the title above, took place at the beginning of December 2020. The doctor was partially blocking the path around the patient in the limited space of the room, a member of staff had to squeeze past them. The doctor commented “oh you have a firm bottom”.

The medical management team involved decided that the second incident was more serious than the first. The first is described as not personally directed and also that had the same remark been made to a different member of staff that this would not have been experienced as offensive. This member of staff had been vocal in raising concerns about the doctor’s return to work and considered to be more sensitive to the doctor’s behaviour.

As a result of the second incident a minor misconduct letter was issued. This highlighted that the doctor’s behaviour was not in keeping with behaviours contained in the RDUH’s Harassment and Bullying Policy or in keeping with the RDUH’s values and behaviours. The letter asked that the doctor apologise to the member of staff concerned, that they write a reflection on their behaviour and that they check with their GMC conditions and determine whether they need to tell the GMC. It is not clear what happened with this aspect.

There is no further information on this incident.

The GMC’s Medical Practitioners Tribunal met on 19 February 2021 and decided to revoke all of the conditions on the doctor’s license. There is no correspondence available to this review that demonstrates whether the information about the inappropriate sexual behaviour was shared with the tribunal at the time.

There are no further concerns raised about the doctor’s return after these decisions were shared and the doctor returned to work.

d. Viewing of an image by subject on their mobile phone whilst working in theatres at RDUH, 2022

On Friday 20 May 2022, a staff member reported that the doctor had been seen looking at a picture of a naked woman on their phone whilst working in theatres. This picture appeared to show a woman naked from the waist up and it appeared as though the woman was covered in a drape, similar to those used in operating theatres. The member of staff discussed this with their manager and a decision was taken to email the medical manager about the event. There was a short delay in response because the medical manager was off sick. However, they responded to a text message they received alerting them to the problem. They immediately phoned another member of the medical management team who took responsibility for starting to manage the process (24 May 2022). Medical managers had

changed since the last episode and this manager did not know about the doctor's previous history prior to becoming involved in this incident. HR were informed and a written statement from the staff concerned had been requested. Discussions considered the need to inform the GMC and PPA. A preliminary fact-finding process was undertaken.

A meeting on 6 June considered the information obtained and the next steps. The information available was sufficiently serious to progress the matter and the RDUH's Safeguarding Team contacted the Police and the local authority designated officer (LADO) as the doctor had had contact with children as part of their clinical role. The incident was formally registered on the RDUH's incident reporting system. HR met with the person who had originally reported the incident, explained the process to them, and thanked them for coming forward. Signposting to any additional support they may need was provided, including support from the Safeguarding Team. An exclusion risk assessment was completed for the doctor.

The doctor was arrested on 8 June 2022. The RDUH worked with the Police to contain the incident and avoid having the doctor arrested on their premises, which would have impacted on service delivery as well as impacting on those who were close to the doctor outside of work. Electronic devices were seized from their home and the doctor was released under investigation. Arrangements had been made that if they were to be released during the process of the investigation that they should not enter the RDUH premises until contacted by the Medical Director.

On 9 June the doctor was formally excluded, they were supported at this meeting by a close family member. The RDUH supported police officers to make the necessary searches within RDUH premises.

On 24 June, the RDUH was made aware of multiple indecent images/videos of children. The doctor had admitted to these. The Police were proceeding to prosecution but made the RDUH aware that this may take several months. The Police were also clear that this information was being shared for safeguarding processes only and could not be used as part of any MHPS or disciplinary processes. The RDUH put processes into place to manage the confidentiality of the information, a process to keep staff informed and to manage any potential breaches in confidentiality. The shock that staff experienced when they realised the nature of the offences when the doctor was finally convicted provides evidence of how successful the RDUH was in containing the information. The police could find no images relating to the RDUH and the offensive material was found to be geo-located in Asia.

The impact upon the small group of staff who knew the full extent of the crime should not be underestimated. One member of the team described how they had seen and heard things no one would ever want to see and hear.

The doctor was absent from the RDUH from the time of their exclusion. However, there were numerous multi professional meetings that the small RDUH team involved in the processes associated with the criminal investigation continued.

The RDUH were aware that the doctor had made an application for ill health retirement towards the end of 2022. The possibility of ill health retirement had been considered with the

doctor prior to the events leading to his final arrest. A psychiatric report was written in March 2023. This report supported the application.

A formal case review meeting took place in March 2023 when the doctor was excluded, but also absent from work because of sickness. This meeting cited that the doctor had made an application for ill health retirement. The doctor had been absent from work for a considerable period of time and the statutory sick pay entitlement had ended. Plans started to be put in place for a hearing to consider dismissal on grounds of ill health, in light of the length of absence from work and their intent to cease work on the grounds of ill health.

A formal hearing took place 18 July 2023, the RDUH case was not contested by the doctor and they were dismissed on the grounds of ill health capability with a paid contractual three month notice period in lieu.

The doctor was eventually convicted following charges in relation to child pornography and sentenced to one year and eight months in prison in March 2024.

Matters of interest to the RDUH but outside the terms of reference

Communication

Following the appearance of the doctor in Exeter Crown Court on Friday 8 March 2024, at which a guilty plea was entered to five charges of downloading and viewing indecent images of children, there was media coverage of the case. Some of the media reports contained detail of the previous conviction in France in 2017 and of the fact that the doctor had been seen watching a video of a topless woman during an operation.

On 11 March RDUH posted an internal news story to staff describing the outcome of the case, the close collaboration with the Police and GMC and the commitment to learning from it. It was clear that RDUH had planned communication in the light of what they knew and how they thought their staff might be impacted. As described, they did not have the full context of the wider staff experience of this doctor. The RDUH also put in place patient helplines and communicated with staff about this external review. When the anaesthetic team realised the wider staff experience and its impact, they immediately set up meetings with staff, which have fed into this report.

Those staff who had worked most closely with the doctor shared with the review team their expectation of a meeting/direct communication with them. For them the media coverage of the case, and the nature of the offences for which the doctor was convicted and sentenced, came as a shock. Staff described being expected to 'just get on with the job' as if nothing had happened. They experienced anger that nobody was thinking or caring about the impact of the shocking news on them as people or on their ability to do their work. Staff wanted to make sure that this experience was shared so that future incidents could be managed in a more sensitive manner.

Conclusion

This is a very unusual case. It is rare for those working within healthcare system to manage a doctor with this level of complexity for whom mental health and criminal behaviours co-exist. It will be outside most people's experience of managing doctors.

There are a number of themes that shine through this review.

The first is the compassionate response that the RDUH took to a doctor who they and regulators considered to be a doctor in difficulty. The RDUH was concerned about the risk of suicide as a result of the mental health issues reported to them. This shaped decision making and the management of this doctor. The mental health and well-being of the doctor were supported throughout these events.

The second is the lenses that different professions saw this doctor through. For each profession the lens through which they saw the doctor and unfolding events created a different view. There was never a consolidation and consideration of these different views to create a rounded picture that may have helped understand the behaviours of the doctor more fully.

The culture within the RDUH at the time about sexual safety and about speaking up reduced opportunities to share these differences. Hierarchical cultures are present in many organisations and teams, and this appears to have been true of the anaesthetic department. Such cultures can contribute to staff feeling that it is difficult to speak up.

It is clear that the behaviour of the doctor was different with different professionals. In particular, it appears that the behaviours that compromised people's experience of sexual safety appear not to have been displayed to other consultant colleagues.

Following the first conviction in France in 2017 there is no doubt that the outcome of the GMC process heavily influenced the approach taken by the RDUH to managing the doctor's employment and support at work. The determination of impaired fitness to practice on the grounds of the mental health issues, and not the conviction, gave the impression that the doctor's health problem was the cause of their offending behaviour. The link to a sexual motivation was rejected and the behaviour was viewed solely in the context the health problem. This was reinforced by the GMC later ruling and removal of restrictions.

In relation to how the doctor was managed through internal RDUH processes at each stage of the case policy and procedure, with the information available, were followed as described for the vast majority of time. When this was not followed, the circumstance surrounding this gave context to why this happened. However, the processes for determining what and how information is escalated was less clear and some information was not escalated that should have been.

There is good evidence to say that the RDUH ensured that the right external organisations were engaged throughout the process. There is no suggestion that the reporting was not in line with what was required, but the review team saw little evidence of what was reported to

the GMC in the periods between incidents. It is not clear whether the GMC had information about the minor concerns this doctor displayed.

The plans to reintegrate the doctor back into work did not work as well as they had been planned for the RDUH or the doctor. As with other complex decisions in this case, ensuring that an appropriately diverse group of professionals is involved would improve this. This doctor's supervision would have benefited from more structure, perhaps regular meetings over a longer period of time and a written record of what was discussed would have made this more robust for the managing team. It might also have been more comfortable and built more trust with the doctor. With hindsight it is quite difficult to develop a supervisory system for a doctor, monitored by doctors, when this professional group is not the group where the behaviours of concern are manifest, and it is not related to a clinical matter.

The final incident was managed by a small senior group of professionals from medical and HR management and from Safeguarding with considerable expertise and discretion. The team were party to some very disturbing and distressing information. They describe themselves as a well-functioning group and provided support to each other and some, but not all, had support outside of this process. They should be recognised specifically for the work they did in this extremely difficult situation. Some in this group feel a degree of anger towards those in higher management of the RDUH who did not appear to trust that they were doing the right thing. This is an opportunity for further learning. For the small expert team tasked to undertake detailed work with outside agencies such as the Police in confidence, dealing with challenging and distressing subject matter, there is a need to explore how they can be supported by senior management in the best way. An incident of this magnitude needs to be led by the Executive team, however there may be opportunities to learn how people work together and communicate effectively in these situations.

It is also important to recognise that the teams directly affected in the surgical division are working together and have started making improvements that are already delivering benefit. These will be recognised in the areas for improvement.

Areas for Improvement

1. The culture of the RDUH

a. Sexual safety

It is principally women who experience unsafe sexual culture, and it is almost always precipitated by men. This subject has received a lot of attention in the press and is being discussed far more openly and with more seriousness than it has been previously. The reviewer is aware that the RDUH already has work underway to improve this aspect of safety, in light of this evidence and a previous review.

This review demonstrates a lack of clarity and understanding about what constitutes a safe sexual culture in the RDUH, the behaviours expected in a safe culture and the impact of unsafe sexual behaviours on those affected by them. Behaviours described within this review, suggesting the wearing of a 'pretty dress' might influence the outcome of an interview, or women's apparent acceptance of sexual banter being used as a determinant as to its acceptability, demonstrate this lack of understanding. There is already work being done in the RDUH to tackle this issue. Improvement must include clear guidance and the knowledge of why such behaviours are detrimental to women. Many doctors and staff more widely, women and men, have grown up and worked in cultures that are now recognised as unsafe. They have become complacent, and many will be unaware of the impacts of these behaviours. The experience of previous trauma is poorly understood. Expectations around behaviour must be coupled with education, to ensure that the behavioural change is driven by knowledge and an understanding of the need to change, rather than driven by a poorly understood organisational obligation to change.

b. Psychological safety

Many people who took part in this review describe feeling unable to speak up, or if they did speak up, an experience of not being heard, their concerns not being valued, or being dismissed, not understood. People described experiencing this when trying to raise concerns specifically about this doctor, but more widely when managing complex concerns about doctors with the Executive team. Within this review the people who experience this were those attempting to raise concerns with people who were perceived as more senior to them, higher up in the hierarchy, importantly, people felt that their voices were much less likely to be heard if they were female and this was not always dependent on position. A failure in people feeling safe to speak up inhibits people sharing concerns or mistakes and results in organisations being blind to problems and those not sharing feeling unsupported and unsafe in their roles.

The RDUH has a large number of internationally trained staff across its disciplines. The culture of the services that these colleagues have trained and worked in are often quite different and may impact on people's willingness to speak up. This difference must be considered when working with this group and approaches need to be sustained overtime for them to be effective.

The ability to speak up about anything is fundamental to safety, however, it should be borne in mind that sexual safety will not be resolved by women feeling able to speak up, but by men behaving in a way that does not cause women to feel unsafe in the first place.

The Trust has a Freedom to Speak Up (FTSU) system which some staff were aware of and was described in positive terms. The RDUH need to ensure that this service is properly resourced to do its important work. A service without adequate resource runs the risk of creating cynicism about the Trust's commitment to its purpose.

The ODP lead and the current medical lead in the anaesthetics department have already put in some structure that supports people being able to share concerns more freely. This is already showing benefits.

The medical lead and department manager have also already facilitated a communal informal space that the department's doctors and trainees can meet in. This helps to flatten hierarchies and builds relationships between doctors, improving psychological safety. It has been universally welcomed by all the doctors spoken to in this review.

2. The systems available to support and manage doctors

a. Review the availability of human resources available to medical managers

There is significant human resources expertise and experience within the RDUH. When medical colleagues have access to the senior resource and experience it is highly valued and impacts on how they make their decisions. For example, the value of HR briefings prior to important meetings and expert advice, guidance and support within complicated HR process is universally highly valued by medical managers. Doctors are trained to be good at being doctors delivering clinical care. Doctors who step up to be part of the medical management team most often have little or no training in the processes of medical management. They continue to do their clinical roles and often have limited time to carry out management tasks. Doctors bring their expertise of understanding their tribes and the nuance of their clinical work and clinical safety. Many medical managers have personal relationships with the people they manage and this, quite understandably, impacts upon their objectivity. Human resources colleagues bring the expertise of process and regulation and are able to give objective advice in complicated situations. Their experience also adds benefit and helps medical managers to understand what may, or may not, be of significance when concerns or observations are made about a doctor. Consideration could be given to having more HR expertise and experience available to medical managers much earlier on, before the point of formal process being considered. Changes since the pandemic have meant that there is far more remote working. Whilst this has benefits there are also consequences that need to be considered and managed. Face to face contact is far more effective in building relationships and trust. Informal spontaneous conversations between medical managers and HR professions can significantly enhance doctors to understand and manage complex medical management situations.

The RDUH separates its medical staffing function (including revalidation) from its employee support and resolution function. The employee support and resolution service is a service for all staff within the RDUH. The contractual arrangements for doctors are different to those from all other employees in the RDUH, in particular, the management of doctors who run into difficulties with their performance. Performance concerns about doctors in the NHS are dealt with under national policy and procedure 'Maintaining High Professional Standards'. This necessitates a different and more complicated approach to understanding and considering performance concerns. This policy covers concerns about both a doctor's clinical performance and concerns about behaviour. Whilst it is clear that senior people in this team have knowledge and experience of this framework, it is not always true for those less senior in this department. HR staff below the lead for the employee support and resolution service, were described as feeling less confident about using this framework, this is further complicated by more junior staff turnover within departments. The RDUH may wish to consider having a medical staffing department that also has the capability to carry out the support and resolution function too, this might allow a smaller team of HR professionals to develop specific expertise, confidence and experience in the processes needed to manage and support doctors well and in the timeliest manner. Relationships and trust contribute to making managing doctors easier.

b. Review systems to store and manage information about doctors

This improvement area relates to the second improvement area described. It is also clear that there has been improvement in this area over the time of this review. Medical and senior HR managers commented that the medical systems in HR had to be rebuilt after it was diminished some years ago. There is an increasingly robust system for managing doctors at the top of RDUH.

However, it has been evident through this review that information about doctors is stored in more than one place and different information is available in these different places. This had been raised by some medical managers before. Medical managers have not always known what should be recorded, how it should be escalated and where it should be stored. This has meant that there has been no one place where a full description of what has happened to this doctor over the course of this review period can be found. This account has been brought together by accessing information from a variety of sources and it is unlikely that the review has had access to all the information that is available in this case. There are a number of consequences to this issue. The story of this doctor has not been shared as fully as it could have been and diluted and lost over time. When information is incomplete or not shared, there is a risk that decisions get taken on inadequate information. This is further compounded when the systems for escalation and transferring information between post and future medical managers are not clear and when information does not transfer between medical managers as they change over time.

The main source of information about doctors, for those managing doctors, needs to be somewhere that is not affected by changes in any personnel. There should be clarity about what is stored there. There should be a clear understanding about what information should be escalated into higher medical discussion fora and process

between medical managers to ensure that crucial information about their doctors is shared in transitions between managers.

c. Review of how decisions are made

This review has highlighted that a number of complex decisions needed to be made about how to manage this doctor safely when he was returning to and continuing to work within the RDUH. These decisions had significant impacts on doctors, but also wider staff groups within the wider work environment. When complex decisions need to be made, it may be helpful to have a more diverse range of expertise involved to aid this decision process. This may help to keep decision's objective, effective and more practical in the complex environments that they need to be enacted in.

For example, when a doctor returns to work into a multidisciplinary clinical environment with changes to their practice needed, it would be wise to include senior members of other disciplines to consider how this can safely undertake (lead nurse, lead ODP and lead surgeons for example). The span of confidentiality needs to include those needed to create the safest decisions possible. Collaborative decision-making builds trust, improves the chances of plans working and helps to manage the inevitable questions and anxieties well and from a position of shared understanding of the problem being managed.

As well as HR expertise, in this case, advice from the Safeguarding Lead may have been helpful too. In any consideration, where a decision is made to go outside process, an object expert HR opinion should always be considered and documented. The final event had a more diverse team involved from the outset and this proved important in its overall management.

It is right that maintaining an individual's confidentiality is important. This must be balanced with safety when managing complex situations.

d. Review how doctors are supervised when they experience difficulties

The structure that the RDUH put in place to support this doctor when they returned to work did not achieve its intended outcome. It was difficult and awkward to execute and experienced as overcontrolling by the doctor. The RDUH may want to consider creating a system of regular supervision meeting with doctors in difficulty. This allows for a fuller conversation to happen and opportunity for some trust to develop between individuals and be experienced as more supportive. The content of such sessions should be agreed and documented to ensure a record of action over time. This supports safety for both parties and creates a record for future management. There needs to be a clear process of escalation for problems that arise for doctors, this should be clear to all parties and again documented as needed.

3. Sharing findings with GMC and PPA

The Executive MD may wish to share these findings with the GMC and PPA. There may be opportunities for learning by all organisations involved in this case.

Appendix A - Dr Helen Smith

A consultant forensic psychiatrist for more than 20 years, I was medical director of Devon Partnership NHS Trust for nearly a decade.

I have significant expertise and experience in patient safety, undertaking the Patient Safety Officer training at the Institute for Health Improvement (IHI) in Boston, USA, before obtaining a postgraduate qualification in Patient Safety and Risk Management, leading the regional mental health safety quality improvement programme and advising the National Mental Health Patient Safety programme for five years. I have recently been part of a team that reviewed commissioned to review Greater Manchester Mental Health Trust after concerns about services were raised by a BBC Panorama programme. I am currently working on a national programme commissioned to improve the culture of all inpatient mental health services in England.

In the context of the National Mental Health Safety programme, I lead the development of national guidance for managing sexual safety in mental health inpatient services.

Appendix B – Terms of Reference

Royal Devon
University Healthcare
NHS Foundation Trust

CONFIDENTIAL – Terms of Reference for External Review of the Trust's Response to the Management of Dr [redacted] (formally known as Dr [redacted])

Terms of Reference for a review into the Trust's response to the management of Dr [redacted] (formally know as Dr [redacted]). This review is being requested and undertaken in line with the Trust's commitment to a Just and Learning Culture. Whilst assurances are being sought by the review, the focus should be on the identification of any learning that can be taken forward and actioned as appropriate.

The review will focus on four specific incidents;

- Inappropriate taking of images in France, 2017
- Drug misappropriation at RD&E, 2019
- Inappropriate comment made to a female colleague December 2020
- Viewing of an image by Dr [redacted] on his mobile phone whilst working in theatres at RD&E, 2022

Inappropriate taking of images in France

To review the Trust's response to the incident reported to the French Police in July 2017, checking that the Trust responded in line with legislation, regulatory requirements and Trust policies and processes, i.e. (Safeguarding, Human Resource policies etc.)

To seek supporting evidence, to consider if;

- The correct suspension risk assessment and outcome process was applied,
- GMC notification was timely and appropriate
- Appropriate arrangements to ensure Dr [redacted]'s wellbeing were considered and made
- The decision to permit Dr [redacted]'s return to work was appropriate
- Governance arrangements on Dr [redacted]'s return to work were in place, were appropriate, with full agreement from the GMC
- Restrictions for return to work were appropriately applied and understood
- Wellbeing and support was considered on an ongoing basis

Drug Misappropriation at work (RD&E)

To review the Trust's response to the drug misappropriation incident reported June 2019, checking that the Trust responded in line with legislation, regulatory requirements and Trust policies and processes.

To seek supporting evidence, to consider if:

- The correct reporting process was followed
- The incident was managed appropriately in line with Trust policy and appropriate and proportionate actions taken
- The decision to permit Dr [redacted]'s ongoing working at the Trust was appropriate
- Occupational Health referral was made and that Dr [redacted]'s wellbeing was considered throughout

Wellbeing and support was considered on an ongoing basis

Consider any cultural context within the anaesthetics that may have impacted the management of the incident.

Inappropriate comment made to a female colleague December 2020
To review the Trust's response to the inappropriate comment made by Dr [redacted] to a colleague whilst working in Theatres, checking that the Trust responded in line with Trust policy and processes.
To see supporting evidence, to consider if:

- The correct reporting process was followed
- The incident was managed appropriately in line with Trust policy and appropriate and proportionate actions taken
- There were any connections / considerations made to the two previous incidents (i.e. inappropriate images in France, drug misappropriation)
- The action taken to the comment was appropriate
- Wellbeing and support was considered on an ongoing basis

Viewing of an image by Dr [redacted], on his mobile phone whilst working in theatres at RD&E
To review the Trust's response to the reporting of Dr [redacted] viewing an image in May 2022 of a naked woman on his mobile phone whilst working in Theatres at the Trust, checking that the Trust responded in line with legislation, regulatory requirements and Trust policies and processes.

To seek supporting evidence, to consider if:

- The correct initial reporting process was followed
- Ongoing internal reporting and escalation and subsequent actions were both timely and appropriate (i.e. were the correct personnel informed, was escalation timely, reasons for any delays, impact/consequence of any delays)
- The reporting to the Police was timely and in line with Trust Policy
- The Trust cooperated appropriately, timely and reasonably with the Police, to ensure valuable evidence was offered/preserved by the Trust
- The Trust's internal arrangements, once it was confirmed that indecent images of children were found on his personnel devices, were appropriate, timely, in line with legislation, and Trust policy
- The handling of the Trust's response to ill health retirement - understanding the rationale for dismissal
- Wellbeing and support was considered on an ongoing basis

In order not to jeopardise the ongoing legal proceedings, the review should conclude at the point the Trust dismissed Dr [redacted] on the grounds of ill health.

Melanie Holley
Director of Governance
January 2024

Appendix C – Timeline

Consultant's Management and HR Intervention Chronology

Date	Details
01/07/2004	Employment start date with RD&E.
05/05/2004	Confirmation of satisfactory CRB (now DBS) check.
10/08/2009	Further satisfactory DBS check.
22-24/07/2017	Arrested by French police due to allegations of taking photographs on their mobile phone of persons in shower cubicles at campsite in Daglan, France. RDUH informed early August 2017 and consultant simultaneously starts period of long-term sick leave. Self-referral to GMC (exact date not known).
07/11/2017	At Bergerac Court of Major Jurisdiction, Correctional Court conviction: *Violation of privacy by attachment, download or transfer of an image of a person of a sexual nature for acts committed in Daglan on 22 to 24 July 2017.* Fined 8127 Euros.
05/04/2018	RDUH officially notifies of conviction in France in line with Trust DBS policy.
10/04/2018	Exclusion Risk assessment undertaken. Three independent psychiatric reports at the time linked offences in France to mental illness. A fourth does not find a link. The risk assessment process concluded return to work (RTW) with the following in place: • Return to clinical duties only. No management responsibilities or out-of-hours commitments. • Signed acceptance of the advanced treatment plan. • Agreement to work with allocated pastoral supervisor(s).
June 2018	RTW on a phased return.
August 2018	A GMC medical practitioner's tribunal (examining the matters in France) makes a finding that fitness to practise was impaired because of ill health (The tribunal imposes conditions on his registration for a period of 18 months. However, permitted to continue practice as a Consultant Anaesthetist).

Date	Details
23/09/2018	'Peeping Doc Safe' article hits the Sun Newspaper.
06/06/2019	Seen by a member of theatre staff putting an ampoule of Bupivacaine (long lasting, topical anaesthetic) into briefcase. This is escalated through management. During a formal MHPS investigation doctor admitted to the misappropriation of the medication for the purposes of self-treating dental pain. A referral was made to the GMC regarding this. Police not contacted or involved.
29/10/2019	First written warning for six months (issued outside of the hearing) for the misappropriation of the anaesthetic medication. Mitigation taken into account, likely re-emergence of mental illness.
23/12/2020	Doctor is issued Minor Misconduct,15 December 2020. This was due a concern being raised over an interaction with a female colleague on 3 December 2020 in the anaesthetic room in PEOC in which the colleague allegedly had to squeeze past him because he would not give her space to get past, and after which he made comment of '*Oh you have a firm bottom'*. There were other concerns about behaviour raised at the same time and mental health was considered. Denied at the time.
27/02/2020	Medical Practitioner tribunal Review hearing (mainly focused on the matters in France, but also now aware of the misappropriation of medication matter) - the tribunal determined that fitness to practise remained impaired and imposed conditions for a further 12 months.
25/03/2020	RDUH receives letter from the GMC Case Examiners to say GMC have decided to conclude their specific investigation into the concerns raised about the misappropriation of medication with no further action.
24/05/2022	Medical managers raise concerns with HR regarding viewing of a picture of a partially naked women with theatre-like drape on phone. Statement requested. Incident happened 20 May 2022, minor delay between incident and response.
27/05/2022	Management team gathered and initial plans made.
06/06/2022	Meeting agreed next steps: • Exclusion risk assessment undertaken. • Safeguarding and then Police involved. • Safeguarding processes implemented. • Formal incident report made.

Date	Details
08/06/2022	Doctor arrested and electronic devices seized.
09/06/2022	Doctor formally excluded.
13/06/2022	Initial Managing Allegations Meeting (MAM) led by local area designated officer (LADO).
27/06/2022	Formal GMC referral involvement of ELA.
05/07/2022	Contact made with PPA (NCAS).
19/07/2022	MAM LADO meeting.
27/07/2022	GMC Medical Practitioner tribunal - interim order of suspension confirmed.
07/09/2022	MAM LADO meeting.
17/10/2022	Sickness case review meeting.
19/12/2022	Further sickness case review meeting, doctor confirms an application for ill health retirement has been made.
29/03/2023	Further sickness case review meeting.
04/04/2023	MAM LADO meeting.
12/05/2023	Further contact with PPA (NCAS).
22/05/2023	Further sickness case review meeting - with knowledge from ill health psychiatric report.
18/07/2023	Ill health capability hearing, dismissal on the grounds of ill health.