Parliamentary Commissioner Act 1967

Report by the Parliamentary Ombudsman into a complaint made by

Dr L

Complaint about

The Care Quality Commission (the CQC)

Summary of our findings

1. We have **partly upheld** the complaint about the CQC because we have found several instances of maladministration, but not all the maladministration claimed. We found that the CQC failed to follow their procedures when handling Dr L's concerns about the fit and proper person requirement (FPPR). In particular, the CQC failed to:

- pass on Dr L's concerns about FPPR to the relevant provider, Trust F;
- record or explain clearly how they reached their decision that Trust F was compliant with FPPR;
- respond to Dr L's comments on the draft investigation report commissioned by Trust F into FPPR after saying they would do so.

2. As a result of these failings by the CQC we consider that the CQC's failure to pass on information to Trust F meant that the FPPR investigation likely took longer than it would have done and prolonged Dr L's upset. Further, that the CQC's handling would likely have caused Dr L to lack confidence in their consideration of Trust F's decision on FPPR. We also found the CQC's failures in communicating with Dr L meant that Dr L lost the opportunity to explore in a timely way what action he could take to prevent Trust F publishing negative comments about him in its FPPR report.

The complaint we investigated

3. Dr L complained that when regulating FPPR the CQC failed to:

a) pass on his complaint about a breach of FPPR to the independent investigation team (the Barristers) for Trust F.
b) follow a robust process for considering FPPR matters and that Trust F were in breach of FPPR in relation to the Chief Executive. This included that the CQC should not have suggested to Trust F that barristers investigate the FPPR matters, when his allegations related to patient safety and safeguarding.
c) failed to consider his comments on the Barristers' draft report and failed to address his complaint. Dr L believes this shows that the CQC's consideration of his complaint under FPPR was unfair and lacked transparency.
d) let him know they were not going to address his evidence/comments on the Barristers' draft report before allowing publication of the Trust F's investigation report. Dr L said the CQC denied him the right to challenge its decision before the report was published.

4. Dr L said that the CQC's suggestion of using barristers and the delays in the CQC giving the Barristers his evidence was costly (£200,000) to the public purse. Dr L told us that he received abuse from individuals over social media (and in a medical journal) who thought he was responsible for wasting public money. In addition, Dr L told us that the length of the Barristers' investigation caused him considerable distress as it was 11 months from his concerns being submitted to the CQC until the independent investigation report was published. Dr L said he did not realise that Trust F knew nothing of his complaint to the CQC and thought he was being harassed.

5. Further, because the CQC did not let Dr L know they were not going to address his evidence prior to publication of the Barristers' report, he said that he was denied any opportunity to take legal advice about preventing the publication of the report which contained untrue statements about him. Dr L said that the CQC's actions meant that, following publication of the Barristers' report, his reputation was damaged and resulted in the press and medical press that followed. In particular, Dr L said he had been told that he was '*an unreliable witness and fantasist*'. He said that he has also been told he has been dishonest and brought disrepute on the campaign for whistle-blower protections.

6. Dr L would like the CQC to acknowledge and apologise for its failures and to withdraw or publish a caveat of its acceptance of the Barristers' investigation report until his objections have been fully investigated. In particular, Dr L would like the CQC to commission an investigation into his objections on the terms in which they were originally expressed, independently and by mutually agreed process. Dr L is not seeking compensation from the CQC but he would like these remedies to be publicised[1].

Legal and administrative background

7. We use related or relevant law, policy, guidance and standards to inform our thinking. This allows us to compare what happened in a complaint with, if necessary, what should have happened.

<u>Our powers and approach</u>

8. Under section 12(3) of the *Parliamentary Commissioner Act 1967,* we can question the merits of a discretionary decision taken by an organisation *only* where there is evidence of maladministration in the way the decision was made. We cannot question a decision on the grounds that we might have reached a different decision from the one that was actually made.

9. When considering the actions of public bodies, we take account of the legislative and administrative standards in place at the time of the events. These standards provide a benchmark upon which we can take a view on if the actions of the public body were administratively sound and reasonable. If maladministration has occurred we can also use these standards to form an opinion on what would have happened but for

[1] Dr L said that financial gain had never been his motive for airing concerns about the mistreatment of NHS whistle-blowers. Dr L said that he had faced hostility on social media which had caused him considerable pain and he hoped the trolling he experienced would cease.

maladministration, and what injustice this has created for the individual making the complaint. Once we understand any injustice that has occurred we can develop an understanding of the appropriate remedy. We have set out the relevant standards for Dr L's complaint below.

10. The Ombudsman's Principles of Good Administration are broad statements of what public organisations should do to deliver good administration and customer service, and how to respond when things go wrong. The Principles that apply in this case are:

- ***Getting it right*** – acting in accordance with the law and the public organisation's policy and guidance; acting in accordance with recognised quality standards; decision making should take account of all relevant considerations, ignore irrelevant ones and balance the evidence appropriately. Further, when assessing risk, public bodies should ensure that they operate fairly and reasonably;
- ***Being customer focused*** - Public bodies should aim to ensure that customers are clear about their entitlements; about what they can and cannot expect from the public body, about their own responsibilities. In addition, public bodies should do what they say they are going to do – if they make a commitment they should keep to it;
- ***Being open and accountable*** – public administration should be transparent; being open and clear about policies and procedures and ensuring that information is clear, accurate and complete; creating and maintaining reliable and usable records as evidence of their activities, stating criteria for decision making and giving reasons for decisions;
- ***Acting fairly and proportionately*** – public bodies should be prepared to listen to their customers, ensuring that decisions and actions are proportionate, appropriate and fair. Further, when taking decisions, and particularly when imposing penalties, public bodies should behave reasonably and ensure that measures taken are proportionate to the objectives pursued, appropriate in the circumstances and fair to the individuals concerned;
  and
- ***Seeking continuous improvement*** – reviewing policies and procedures to ensure they are effective; ensuring the public organisation learns lessons from complaints and uses these to improve services and performance.

FPPR legislation

11. In light of concerns about safeguarding patients and ensuring appropriate leadership in the NHS, Regulation 5(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Regulation 5)[2] was passed in November 2014. It set out FPPR requirements for providers for the appointment of senior directors, including Chief Executives, working in NHS Trusts. The CQC was not able to prosecute providers for non-compliance with FPPR, but could issue requirement and enforcement notices and withdraw a provider's registration. Among other things Regulation 5(3)(d) required providers to consider when appointing directors that:

[2] FPPR is also referred to as Regulation 5 throughout this report.

'*the individual has not been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity*'

CQC's policy, guidance and approach to FPPR

12. There are two routes for the CQC to consider FPPR matters. The first is through their inspection of providers. Inspectors will consider FPPR in the context of whether providers have undertaken appropriate checks (Disclosure and Barring Service (DBS), bankruptcy, references, etc.) for their directors. The second route, which is the focus of this complaint, is the CQC's consideration of information of concern it receives about FPPR breaches from third parties, members of the public and so on.

13. *Regulation 5: Fit and proper persons: directors, NHS bodies, Information for CQC staff* from November 2014 (the 2014 Guidance) and the updated version from March 2015 (the 2015 Guidance) were the guidance relevant to the CQC's actions during most of the period relevant to the complaint. We will use the 2014 and 2015 Guidance, therefore, to consider the CQC's actions on this complaint. They said that the CQC would not determine what is and is not serious mismanagement and misconduct, but would make a judgment about the reasonableness of the provider's decision.

14. The guidance said that when the CQC received information of concern, it convened an FPPR Panel if needed[3], including the Chief Inspector of Hospitals and Director of Legal Services[4]. The guidance said that if the FPPR Panel decided to progress the allegation, the CQC would ask the director whom the concerning information was about whether the CQC could pass the allegation to their provider. If the CQC did not receive consent from that director the CQC would consider whether they would still share the information with the provider in accordance with data protection legislation. The FPPR Panel would make no judgment about the information of concern it had received. Rather, when the FPPR Panel received a response to the FPPR concerns from a provider, it would consider whether the process that the provider had followed was robust and thorough and if it had reached a reasonable conclusion.

15. The 2014 and 2015 Guidance said that if the provider did not follow a robust process or made an unreasonable decision , the FPPR Panel could request further dialogue with the provider, schedule an inspection or take regulatory action (if a clear breach was established). The 2014 and 2015 Guidance said that the CQC would support staff in making the right decision through training, a compendium of case histories and a frequently answered questions (FAQs) document that the CQC updated regularly.

16. At meetings with the CQC, members of the CQC's FPPR Panel told us that some decisions were subjective which was why the FPPR Panel was in place to ensure consistency. It was open to the CQC to take a different view from the provider. They said that the CQC decisions were rooted in the consideration of evidence, consistency, proportionality and reasonableness. In particular, the CQC looked at whether the

[3] The CQC told us that just after FPPR regulations were introduced, they would pass all third party referrals to the FPPR Panel unless it was not possible to identify the relevant director.
[4] This refers to the Director of Governance and Legal Services.

provider made a decision that a reasonable trust could have made – there was a spectrum of what may be reasonable, and the assessment is whether or not the decision falls within that. Specifically, if the CQC saw an issue arising from an anomaly in the FPPR process, CQC would look at it more closely.

17. The CQC's Enforcement Policy from April 2015 said that the CQC can issue requirement notices when there is a breach of regulation, but people using the service are not at immediate risk of harm. The CQC issue warning notices when NHS trusts are not meeting conditions of the registered person's registration [5] and the CQC impose a timescale for improvement. If providers do not comply with the CQC's enforcement action, their registration with the CQC is at risk. Providers can challenge the CQC's enforcement steps. Warning notices and the imposition of conditions on registration, or the variation or cancellation of registration, carry rights of appeal.

18. If actions reach the threshold of serious mismanagement or misconduct, CQC said that providers should consider whether the individual director played a central or peripheral role, and whether there were any mitigating factors.

Background

19. Trust H employed Dr L as a paediatrician from 1993. Trust H also employed the Chief Executive from 2003. Dr L's difficulties with Trust H began when, among other things, he expressed concern about a fellow consultant's treatment of a child who died, Child M, in 2006. Subsequently, Trust H removed Dr L as Clinical Director and suspended him for a period, before he returned to work in a different role. Dr L expressed concern about the way Trust H had managed both him and his concerns.

20. Trust H investigated Dr L's concerns independently through an Independent Review Panel (IRP). The Panel considered that the paediatric department was poorly led from within and had not worked together as a team over a long period of time. The Panel said that the decision to remove Dr L as Clinical Director was the right decision however his exclusion from Trust H was the wrong decision. The Panel said that communication failures by Trust H and the process followed by Trust H after Dr L's suspension had intensified distrust.

21. In December 2010 Trust H dismissed Dr L. Dr L was unsuccessful with claims of unfair dismissal to the Employment Tribunal in 2012 and 2013.

22. The Chief Executive left Trust H and began working at a new trust, Trust F, as their Chief Executive in January 2011.

23. Dr L published a book about his experiences of working in the NHS in April 2014. This included details of Child M's death and it made criticisms of the Chief Executive in relation to Child M and the Chief Executive's management of him/Trust H. Dr L considered that this book presented evidence that the Chief Executive was culpable for ignoring patient safety concerns at Trust H and the way these concerns had been managed.

[5] It is a criminal offence for providers to carry out care services without being registered with the CQC.

24. In June 2014, Trust H published an expert report (the W Report), which had been commissioned by them, into Child M's death. The W Report found serious errors in Trust H's handling of Child M's case including that Trust H could have prevented his death. Trust H apologised to Child M's relative for his care and for their subsequent investigation not being sufficiently robust.

Key events

25. Trust F received an anonymous letter from one of its consultants on 5 January 2015, two months after the FPPR regulation was passed (Annex, paragraph iv).The consultant copied the letter to the CQC. The consultant made a number of allegations about the Chief Executive's fitness as a director in relation to their conduct at Trust H, and referenced Dr L's book as evidence.

26. On 11 January 2015 Dr L emailed the CQC. Dr L said that he did not consider that the Chief Executive's behaviour at Trust H met FPPR. He alleged four main failings – that the Chief Executive covered up failings in the care of Child M; suppressed a Royal College of Paediatrics report; attempted to pay him a settlement to leave Trust H quietly; and refused to deal with a bullying management culture at Trust H. Dr L also told the CQC that he had been sent a copy of the anonymous letter of 5 January 2015.

27. The CQC wrote to Trust F, the Chief Executive's new employer, on 16 January 2015. The CQC asked what action Trust F were taking about the anonymous concerns in relation to FPPR that Trust F had received on 5 January 2015. The CQC did not mention Dr L's allegations of 11 January 2015.

28. In February 2015, the CQC asked Dr L to provide a timeline of events in order to help them process the large submission he had made to them. Dr L provided the timeline as well as the IRP report and W report. The CQC told him that they would consider the Chief Executive's case at an FPPR Panel in March 2015. In an email of 18 March 2015 Dr L told the CQC Inspection Manager that he was *'impressed with your meticulous work in putting the time-line together. Many thanks for that.'* The CQC suggested to us that this showed Dr L was content with the CQC's consideration of his information.

29. Trust F told the CQC on 18 February 2015 that they had completed an investigation into the Chief Executive and FPPR in light of the allegations received about the Chief Executive's conduct at Trust H. Trust F considered that the Chief Executive was a fit and proper person. They noted that the allegations related to another trust, Trust H, and they did not have the power to investigate past events at Trust H. Trust F attached their investigation report to support their conclusion. In addition, on 2 April 2015 the Chair of Trust F wrote to the CQC. He noted that the CQC had indicated they were likely to seek further information from Trust F on the matter. The Chair said that Trust F had no more detail and expressed concern about the amount of time the matter was taking up.

30. On 9 April 2015, following a meeting with the FPPR Panel in March 2015, the Chief Inspector of Hospitals wrote to Trust F. The CQC were not satisfied that Trust F's investigation was sufficiently robust, in particular because they had not consulted Dr L, the author of the book outlining the allegations. The CQC outlined concerns with the process Trust F followed. They said there was a lack of explanation as to how Trust F had reached their conclusion. The CQC said that Trust F did not comment on the Chief Executive's involvement with Child M's death or Dr L's dismissal from Trust H. The

CQC said that trusts should take their own legal advice and whilst they noted the all-consuming nature of the tasks carried out, the CQC could not find Trust F's response to be adequate. The CQC noted that whilst it would not be prescriptive about what action trusts should take, one trust had appointed an independent barrister to investigate FPPR matters. The CQC again did not mention Dr L's allegations of 11 January 2015.

31. On 21 May 2015 Trust F wrote to the CQC telling them that they had appointed a barrister to undertake an independent investigation and another barrister was assisting. They enclosed the Terms of Reference (TOR). Trust F said that the Barristers were aiming to complete their investigation in August 2015.

32. From 9 June 2015 Trust F's solicitor (not the Barristers) made attempts to contact Dr L, to obtain his participation in an investigation. Dr L responded by asking Trust F's solicitor not to attempt to contact him again. He told us that he thought Trust F were harassing him. Dr L's response led the Barristers to email the CQC and copy in Dr L on 19 June 2015. They explained the background of the investigation and said that they were keen to have Dr L's assistance as he was a very important witness.

33. The papers for the FPPR Panel Meeting on 19 June 2015 included a briefing discussing the information from Dr L received in January and February 2015. The CQC said that they did not forward this evidence as they had not gone through it to say whether it was sufficiently concerning, corroborated or whether it implicated the individual. The CQC noted that the volume of information from Dr L was vast and they did not have capacity to deal with it. The CQC noted that it could supply Dr L's information to Trust F, but were unsure how in keeping this was with their policy position (that it was for the provider to assess FPPR and that they only forward information if it met their threshold for doing so[6]). The CQC said that they had no role in any trust investigation and they would expect Trust F to have sufficient processes in place for FPPR and to identify any further evidence. They made no decision about what to do with the information from Dr L. Rather, the FPPR Panel decided to write to Dr L encouraging him to co-operate with Trust F and reminding him that providers were responsible for investigating FPPR, not the CQC.

34. On 22 June 2015 Dr L emailed the CQC and copied in the Barristers. He repeated his allegation from 11 January 2015 that it was not clear to him if Trust F's board had acted appropriately (by looking into his concerns about the Chief Executive) when his book was published in April 2014. He considered them to be in breach of FPPR. He said that the Barristers' email of 19 June 2015 was the first indication he had had that Trust F's work was anything other than an internal investigation. He asked whether it was the anonymous letter (of 5 January 2015) Trust F received or the submission he made to the CQC on 11 January 2015 which prompted the Barristers' investigation.

35. The Barristers responded to the CQC and Dr L on 23 June 2015. They raised concern that their TOR was confined to the Chief Executive's actions and not to those of Trust F's Board, which Dr L's email of 22 June 2015 said should have been included. They clarified that it was the anonymous letter from 5 January 2015 and the subsequent correspondence between Trust F and CQC which prompted the investigation. The

[6] The CQC said that they would not forward allegations where the director was not working in the NHS or could not be traced.

Barristers said that they and Trust F (as far as they knew) had not seen Dr L's correspondence with the CQC during this time. Therefore, the Barristers asked the CQC or Dr L to send them copies of all relevant communications urgently, given they were undertaking their interviews at that time.

36. The CQC emailed Dr L on 23 June 2015. The CQC said that they did not understand why he had asked Trust F not to contact him and that it was for the Trust to investigate the fitness of the individual director, not the CQC. The CQC told Dr L they would expect Trust F to undertake a thorough investigation and they encouraged Dr L to co-operate with them.

37. On 25 and 26 June 2015, respectively, the Barristers and Dr L complained to the CQC that the CQC had not passed Dr L's allegations of January 2015 to Trust F, so the Barristers had no knowledge of them. The Barristers said that they needed all the relevant information urgently if they were to proceed with interviews as planned. Dr L said it was ludicrous that six months after he made his detailed submission the CQC had not given the investigators his evidence. Dr L concluded that the CQC were not taking its responsibilities for FPPR seriously.

38. The FPPR Panel exchanged emails on 25 June 2015 outside the formal Panel meeting. The CQC considered that the anonymous letter had already triggered their process before they had been able to order Dr L's evidence into a timeline for consideration. The CQC considered that on receipt of Trust F's response of 18 February 2015 they used their analysis of the detailed evidence[7] to inform their view of Trust F's response. The CQC also noted that Dr L was included in the Barrister's email of 23 June 2015 and as he had not forwarded the evidence, they assumed he did not wish them to do so. The CQC said that they were taking into account their data protection responsibilities to Dr L and the Chief Executive – they needed to process information fairly and liaise with the Chief Executive and Dr L if they were proposing to pass it on. The CQC noted there was a high impact on Dr L if they disclosed his evidence.

39. The Director of Governance and Legal Services had not been at the FPPR Panel and responded to colleagues later the same day. The Director of Governance and Legal Services noted that, in relation to the Chief Executive's personal data, the book by Dr L was published (so in the public domain). The Director of Governance and Legal Services said that there may be a basis for sharing it as Trust F had commissioned an investigation into FPPR and indicated that it was unclear why Dr L had not just sent this directly to the investigation. The Director of Governance and Legal Services suggested that the CQC give the Barristers a list of what they had and explain what steps they were taking to share it with them. In particular, it was clarified that the CQC should make clear to Dr L that they were co-operating with Trust F's investigation and that they were likely to share a document from him.

40. On 26 June 2015 the CQC sent the Barristers Dr L's submission of documents[8] and informed Dr L of this. The Barristers' acknowledgement email to the CQC repeated that

[7] It is not stated what the CQC's analysis involved and how that related to the CQC's previous position (paragraph 33) that they had been unable to consider the volume of evidence passed to them.
[8] Whilst the Director of Governance and Legal Services said that Trust F should be sent a list, the FPPR Panel note of 8 July 2015 said that the entirety of Dr L's submission was sent to Trust F/the Barristers.

Trust F should have been sent these documents at the outset. The Barristers told the CQC that they were deferring their interview with the Chief Executive until they had considered the new document and spoken with Dr L.

41. Trust F wrote to the Chief Inspector for Hospitals on 8 July 2015 to complain that the CQC withheld documentation and information from them and the Barristers in relation to FPPR. Trust F said this evidence only came to light towards the end of the investigation and that evidence gathering had to be suspended. Trust F said that some witnesses would have to be re-interviewed. Further, that the TOR had been revised and would be sent to the CQC shortly. Trust F said that the new information had affected their investigation costs which were anticipated to be £65,000 more than the £100,000 originally anticipated.

42. On 8 July 2015 the FPPR Panel discussed whether the CQC should forward referrers' information in full to providers. The FPPR Panel said that at present the CQC only provided a summary, which avoided the uncontrolled disclosure of defamatory information about individuals. The CQC noted that they could ask referrers to send the information directly to providers themselves, but said that this would not work where whistleblowers wished to remain anonymous. The FPPR Panel said that where referrers wished to remain anonymous they would send the Trust a summary and ask the Trust if they wanted the information in full.

43. The CQC responded to Trust F's concerns about disclosing Dr L's submission on 17 July 2015, noting that the Barristers did not consider the investigation would be prejudiced by any delay in receiving information and that any '*misapprehension*' had now been rectified. The CQC offered to discuss the process further when the investigation was concluded. This letter was copied to Dr L and the Barristers.

44. The Barristers shared their draft report with the CQC and Dr L on 16 and 17 September 2015, consecutively, setting out their view that FPPR had been met and that they had no concerns about the Chief Executive. Further, they noted that Trust F wanted to ensure that the process was transparent, so Trust F was intending to publish their findings and recommendations at least in summary form. The Barristers' draft report said they were not minded to uphold Dr L's concerns. They considered that there was no evidence that the Chief Executive had any personal or managerial responsibility in relation to Child M's death. The Barristers said there were dangers in treating the W Report (paragraph 24) from June 2014 as findings of fact when it was a desktop review. The Barristers found Dr L to be an *'unreliable witness'*. They said he had *'fabricated'* elements of his story and was overly reliant on his book rather than his own recollection when he gave evidence. The Barristers concluded by saying of Dr L:

> *'it is extremely unfortunate that a man who seems to have so much energy, and to be so prepared to expend it in advance of public good, is also capable of misinterpreting or misrepresenting matters, and to do so in order to propound what we consider to be a misguided campaign. …we are simply noting that his campaign against [the Chief Executive] has been utterly unjustified.'*

45. The FPPR Panel at the CQC met on 30 September 2015 and discussed the Barristers' draft report. The FPPR Panel thought the report showed a '*very thorough investigation had been undertaken*'. However the FPPR Panel had (unspecified) questions about some of the statements in the Barristers' draft report. The FPPR Panel said their questions led

them to question how fair/accurate the Barristers' findings overall might be. The FPPR Panel expressed concern about some of the Barristers' harsh language towards Dr L. The FPPR Panel said that they would further review the Barristers' draft report before sending their response to Trust F. The FPPR Panel agreed they should look at:

- whether the report had robustly addressed allegations about FPPR;
- whether the report answered CQC's concerns from 9 April 2015;
- whether there was anything to indicate the report findings were not reasonable, for example their dismissal of the W report on '*flimsy grounds*'; whether there were any comments the CQC wanted to provide.

46. The FPPR Panel noted also that Dr L's submissions to them in January and February 2015 fleshed out the main FPPR issue but were not a different set of matters to those set out in the anonymous letter. The FPPR Panel said that they would have expected Trust F to have contacted Dr L so he could give them the information directly. The FPPR Panel said that they should compare the detail of the investigation to the questions posed to Trust F in their letter of 9 April 2015 and the W Report.

47. On 5 October 2015 the Director of Governance and Legal Services responded to the FPPR Manager at the CQC in relation to some tracked change comments[9] the FPPR Manager had made to the Barristers' draft report and had sent to the FPPR Panel members. The Director of Governance and Legal Services said that they needed to be clear about whether the Barristers' draft report got Trust F over the line with regard to FPPR, even if the form of the Barristers' draft report was not what the CQC would have chosen. The Director of Governance and Legal Services said that it was not clear whether the deficiencies in the Barristers' draft report meant that Trust F had not complied with FPPR, or whether the CQC would have preferred that the Barristers' draft report covered more ground. The Director of Governance and Legal Services said they had lost sight of some of the detail on the case and queried if questions in the [9 April 2015] letter were really fundamental to the question of fitness.

48. On 9 October 2015 the Chief Inspector for Hospitals emailed colleagues in the CQC saying that having read the Barristers' draft report in full, it did get Trust F '*over the line*'. The Chief Inspector for Hospitals considered there was insufficient evidence that the Chief Executive was responsible for specific failings at Trust H and that the CQC should tell Trust F this briefly. The Chief Inspector for Hospitals said also they should ask Trust F to amend comments about the CQC's role and say that the CQC reserved the right to publish correspondence if Trust F did not make appropriate changes.

49. Later on 9 October 2015 the CQC emailed Trust F to say that the CQC accepted the draft report's broad conclusions. The CQC added:

> *'Our comments have been confined to whether the investigation has been thorough and the decisions reasonable. For the avoidance of argument I would like to make it clear that this response should not be taken as our endorsement of the report.*

[9] We have not seen the tracked comments made by the FPPR Manager.

Whilst we can understand why some of the drafting is as it is, I am uncomfortable with the harshness and volume of criticism towards Dr [L]. ...'

50. On 12 October 2015 Dr L sent two separate emails both with an attached letter to the CQC, the Barristers and the Chair of Trust F. Dr L said that this was his preliminary response to the Barristers' draft report. He also said that he was formally complaining to the CQC about the conduct of the Barristers' investigation. Dr L's covering email said he wanted Trust F/the Barristers not to contact him now that he had registered a formal complaint with the CQC. Dr L told all parties that he intended only to deal with the CQC until he was instructed by them (the CQC) to do otherwise. Dr L complained that the Barristers' draft report:

i) showed evidence of unconscious bias towards the Chief Executive;
ii) showed a lack of knowledge and competence in areas of healthcare, patient safety and safeguarding. Dr L requested that the Barristers take advice from experts in patient safety and safeguarding;
iii) made un-evidenced allegations about him. Dr L noted that the Francis report[10] had referenced treatment of complainants in the same way he was being treated:
'A greater priority is instinctively given by managers to issues surrounding the behaviour of the complainant, rather than the implications for patient safety raised by his complaint'; and
iv) had not made a serious effort to understand his allegations as a whistle-blower – that Dr L was trying to highlight lessons, not pursue the Chief Executive.

51. The FPPR Manager emailed Dr L's concerns to the FPPR Panel members on 12 October 2015. The Director of Governance and Legal Services responded to the FPPR manager on 13 October 2015 saying that the CQC were not responsible for the Barristers' investigation. Rather, the CQC's role related purely to whether Trust F was meeting its obligations under Regulation 5. The Director of Governance and Legal Services said the CQC had concluded that the Barristers' draft report provided the CQC with an adequate degree of assurance in relation to Trust F's position under Regulation 5. The Director of Governance and Legal Services added:

'This does not mean that we are adopting its conclusion, or otherwise endorsing its contents. Nor are we going to provide any further commentary on the report. We really can't be a go between for Dr [L] in relation to his complaint – it has to be up to him to take that forward.'

52. The CQC emailed Dr L to acknowledge his email on 15 October 2015 and set out how they would respond to his emailed concerns. The CQC told Dr L:

'I am writing to let you know that [the Chief Inspector of Hospitals] has received your email about the report and will get back to you on this once we have considered it in full.
This will be after 24 October 2015. We will respond to you after this time.'

[10] Sir Robert Francis wrote a report following his enquiry into failings at Mid Staffordshire NHS Foundations Trust, recommending that there was a proper degree of accountability for senior managers and leaders.

53. The CQC discussed the case at the FPPR Panel on 15 October 2015. They noted Dr L's concerns but considered that the CQC could take the FPPR matter no further under Regulation 5 as there was nothing in the Barristers' draft report to suggest that the Chief Executive was unfit. The FPPR Panel also said that *'Our previous [FPPR Panel] concluded that the Trust's investigation had been robust and thorough enough for Regulation 5.'* The CQC agreed to draft a reply to Dr L, but to hold off sending it until the Barristers' final report was received and considered.

54. The Chair of Trust F wrote to the CQC on 28 October 2015 in response to the points raised in the CQC's letter of 9 October and to enclose the final report (which was largely unchanged). Trust F said they had noted Dr L's emailed complaint to the CQC (paragraph 50) and did not accept his criticisms of the conduct of the investigation. Trust F considered the Barristers had followed a fair procedure which satisfied the requirements of natural justice. Trust F considered that there was no evidence of the Barristers being biased. Trust F told the CQC they were aiming to publish the report on 1 December 2015[11]. Further, Trust F said that the costs of the FPPR investigation were now in the region of £200,000.

55. The Barristers emailed the CQC on 28 October 2015 however the CQC were unable to locate this correspondence. The CQC thought that it related to the Barristers' amendments to their investigation report and the CQC's comments.

56. The FPPR Panel met on 4 November 2015. However, the CQC decided to close the case. The CQC said Trust F were compliant with Regulation 5 and the Barristers' report reasonably concluded that there was no misconduct or mismanagement by the Chief Executive.

57. The Chief Inspector for Hospitals wrote to Trust F's Chair on 5 November 2015 to acknowledge receipt of their letter of 28 October 2015. The CQC said that the FPPR Panel had met on 4 November 2015 and did not consider Trust F had breached Regulation 5. They said the *'CQC does not accept Dr [L]'s criticisms of the investigation and will be taking no further action in this regard.'* The CQC also said they would not update Dr L again until 1 December 2015 (when the final report was due to be published).

58. On 17 and 25 November 2015 Dr L emailed the CQC asking about a response to his complaint, which the CQC told him they would send him '*some time*' after 24 October 2015 Dr L asked the CQC what '*some time*' meant and for a firm date for their response. Dr L told the CQC his view that Regulation 5 was ineffective and the legislation as used by the CQC was woefully biased in favour of trusts and their directors.

59. The Director of Governance and Legal Services and the Chief Inspector of Hospitals emailed each other on 27 November 2015. They said Dr L had no right to get information any sooner than 2 December 2015, when Trust F's report was published, as it was not the CQC's report. They said that it would be premature to refer to the CQC's own position in advance of Trust F's report.

[11] The report was published on 2 December 2015.

60. At 7am on 1 December 2015 Trust F emailed Dr L to inform him that the investigation into FPPR was concluded and that the CQC had accepted the Barristers' conclusion. Trust F said that the report was being published just after midnight on 2 December 2015.

61. At 10.30am on 1 December 2015 Dr L emailed the CQC to ask how the Barristers' report could be published when he had detailed why it was biased and unfair. Dr L said that the CQC had not been in touch with him about his complaint for seven weeks and said that if his complaint was upheld the Barristers' investigation report would be null and void. Dr L said that surely this was a gross breach of any reasonable process as his complaint to the CQC should be settled before the Barristers' report was published. Dr L said that he needed time to discuss a Judicial Review about the way that the CQC had handled his complaint under Regulation 5.

62. On 2 December 2015 Trust F published the Barristers' report on FPPR and the Chief Executive. On the same day, the CQC wrote to Dr L to tell him that they were satisfied that the Barristers' investigation had looked at the issues raised and that Trust F had not breached Regulation 5.

63. There was some media coverage of Trust F's report on 2 December 2015[12] on the £200,000 cost of the FPPR investigation which allowed readers to comment. The article reported Trust F's criticisms of the CQC for failing to pass them information which increased their costs for the investigation. Among other comments from members of the public, it included an anonymous comment:

> *'We have paid for Dr [L]'s campaign against [the Chief Executive] and others through ET, EAT and FPPR. How much? Who knows. To what end? Dr [L]'s determination that his personal narrative be accepted? This report suggests there is no basis for this pursuit. As did the [Employment Tribunal]; as did the [Employment Appeal Tribunal]. Who has paid for this campaign? [The Chief Executive] and the public purse. Was it worth it? His claims of culpability and malfeasance in public office are not true and not representative of a wider public interest issue. He has neither proved his point or a wider point. He has simply spent our money on his vanity project.*
>
> *…not all whistle blowers actually are whistle blowers. Some are simply chronically embittered trouble makers.'*

64. Dr L responded to the CQC on 9 December 2015. He reiterated the matters he raised on 12 October 2015. He said that the CQC had assured him on 15 October 2015 that they would get back to him about his concerns. Dr L said that he felt deceived by the CQC into thinking that his complaint was being addressed and he would get a response. Dr L said that he was looking into obtaining a judicial review unless he received a satisfactory response.

65. On 23 December 2015 Dr L approached Counsel for legal advice about launching judicial review proceedings against the CQC for their handling of the FPPR matters. He

[12] https://www.hsj.co.uk/quality-and-performance/cqc-criticised-for-errors-leading-to-trusts-200k-fit-and-proper-person-bill/7000791.article#commentsJump

told Counsel that CQC had failed to properly take account of his concerns about the Barristers' draft report and their acceptance of it was unfair.

66. On 31 December 2015 the Chief Executive retired.

67. The Chief Inspector of Hospitals wrote to Dr L on 7 January 2016 with the CQC's response to his complaints about Trust F. The CQC said that they did not have the legal powers to investigate individual complaints about FPPR. The CQC said they had made arrangements for Dr L's concerns about Trust F and FPPR to be investigated and they had considered the Barristers' report. Having done so, the CQC saw no evidence of mismanagement by the Chief Executive. The CQC acknowledged that Dr L was expecting them to consider his complaint. They apologised to Dr L for not providing a more detailed update at the time [in October 2015] to explain why this was not possible. The CQC said that they did not intend to mislead Dr L and that they were sorry that he perceived that they misled him. The CQC said they hoped their letter offered Dr L the clarity he was seeking.

Evidence we considered

Dr L's comments

68. Dr L said that even if Trust F had a copy of his book, they did not have a copy of the allegations that he sent to the CQC on 11 January 2015. Dr L said his submission to the CQC refined his specific complaint against the Chief Executive down to four main issues. Dr L said that without access to these specific itemised complaints the Barristers would not know where to start as the submission to the CQC was a tiny part of what was in the book. Dr L noted that the CQC were aware that his book (paragraph 23) had been in the public domain since 2014. He said that if the CQC were unsure about data protection issues they could have requested his permission to forward his submission to Trust F, or asked him to send it to them directly. Dr L said that the CQC's actions meant that there was a five month delay in the investigation as the Trust would have received his submission in January 2015 rather than June 2015. Dr L noted that the Barristers said that his submission to the CQC had doubled their work and he considered that it resulted in a spurious investigation report being produced. Dr L said that it was striking that within three weeks of the Barristers' draft report, the CQC had read, assessed and approved it. Meanwhile, the CQC had not been able to read his submission to them from January 2015 within six months.

69. Dr L said that on 12 October 2015 he asked the Barristers not to communicate with him while the CQC dealt with his concerns about their report. Dr L said that his request was based on his understanding that the CQC had already dismissed one report from Trust F and that the CQC had regulatory oversight in these circumstances. Dr L said that he thought registering a complaint with the CQC about their handling would halt Trust F's FPPR investigation. Dr L said that the CQC had already demonstrated that they had authority to accept evidence of failings in an FPPR investigation report and require a trust to do further work (paragraph 17). In particular, Dr L said that the W report (paragraph 24) was not only evidenced and conclusive, but the failings had been accepted by Trust H. Dr L said Trust H had made a full public apology as a result of the W report and, therefore, the CQC should have known the Barristers were wrong to dismiss it.

70. In relation to the CQC's handling of his comments on the Barristers' draft report, Dr L told us that the CQC acknowledged that there were harsh comments about him and that they must have known that publication of the Barristers' report would damage him. He said that the CQC's approach to handling his comments:

> *'This cannot have been a simple procedural error. It was as I have said elsewhere a deliberate and protracted strategy to ignore my complaint leaving me with the impression that it was being dealt with until it was too late for me to do anything about it. …*
>
> *It is for these reasons that I believe CQC treated me unfairly. I believe that a fair and independent examination of my evidenced complaint would have prevented the report being published and would have protected me from the injustices I suffered as a result. The few hours' notice I had of the publication of the report were insufficient for me event to take legal advice on my position.'*

71. Dr L said that as a result of Trust F's costs increasing – because of the CQC's failure to pass on his submission to Trust F – it had generated negative media headlines (paragraph 63). Dr L said that the contents of the Barristers' report were damaging to his reputation and he received negative feedback. As an example of the negative feedback he received, Dr L sent us a copy of a comment made on social media in October 2018 that said:

> *'[Dr L]*
> *One of the problems for the CQC is that they occasionally receive vindictive complaints from recalcitrant and deluded people. One such case involved [Trust F] and their CEO in 2016 [sic[13]]. Recall that one?'*

72. Dr L said he would have done his utmost to prevent the Barristers' report being published and forced the Barristers into responding to his particular points of concern. Dr L speculated that it was possible that the FPPR issue might be ongoing if that had been allowed to happen.

The CQC

73. In relation to Dr L's concern that there was a delay passing the Barristers his information about FPPR – between January and June 2015 – the CQC told us that there was a more proportionate way to consider matters. This included the surrounding events and took account of mitigations Dr L and the Barristers' could have taken. They said that the Barristers' contacted Dr L within 21 days of being appointed and:

> *'what delay there was did not prejudice the inquiry, or make any difference to the conclusions…*
> *…*
> *The Terms of Reference [from the Barristers] also sets out that the independent investigation team will seek out information, and that they will also take their own steps to obtain information from third parties. Therefore it was never clear to CQC why [the Barristers] did not call for evidence as would have been normal*

[13] This should say 2015.

for an investigation of this type, and why there was an expectation that material given to CQC by a third party would be shared with the investigation by CQC without a formal request. Prior to this CQC had already shared information with [Trust F] in the form of a summary which was the practice at the time, and in addition the Trust itself had also received the information directly in the form of the anonymous referral (and Dr [L]'s book) which also set out the concerns regarding [the] Chief Executive …

It was not unreasonable for CQC to assume that Dr [L] himself was in contact with the investigation, given that it was he who had raised the concerns and an interest in sharing his information direct. However, when requested, CQC immediately addressed the concern about a delay in the supply of information'

74. In relation to Dr L's concern that Barristers should not investigate FPPR concerns about patient safety and safeguarding, and that the Barristers did not take evidence from a patient safety professional, the CQC said:

'At that point in time, because the regulation was still new in terms of implementation, one other Trust had successfully used an independent counsel to carry out an assessment of an individual's fitness within the terms of FPPR, and CQC – whilst specifically avoiding making a recommendation – informed the Trust of this fact. This was to enable Trusts to share their experience of operating the new regulation, and learn from each other, should they wish to do so. It was therefore the Trust's decision…'

75. The CQC told us about the approach they took in this case when corresponding with Dr L and considering FPPR:

'…Although the detail is not included in the Management Review Meeting minutes there is reference to 'special meetings of FPPR panel'. Un-minuted discussions between [the Director of Governance and Legal Services, the Chief Inspector of Hospitals and the Deputy Chief Inspector of Hospitals] took place to go through the embargoed report on what CQC could comment on.
To repeat, CQC did not reach a conclusion on Dr [L]'s concerns, and would never have been in a position to do so. Dr [L] disagreed with the investigation's conclusions, and the place for him to raise those concerns were with the investigation team, not CQC. …'

76. In relation to Dr L's concerns that the CQC ignored his comments on the Barristers' draft report and allowed Trust F to publish the report, the CQC told us:

'As it was an independent investigation, CQC had no role in relation to either securing or denying Dr [L] any opportunity to complain and neither would it have been appropriate for CQC as the regulator to interfere in the Trust's operational decisions- it was for Dr [L] himself to communicate his dissatisfaction with the Trust that had commissioned the investigation, and with the investigator…'

As the records will indicate there were at the time a number of different matters which CQC were in communication with Dr [L] about. This therefore made it hard for CQC to have a single point of contact for all his communication. We recognise

that this may have had an impact on how CQC managed his expectations and his understanding of the various processes.'

Our findings

77. Dr L's complaint is that the CQC's process for considering his FPPR allegations about the Chief Executive was not robust or fair. To address this we have concentrated on the key elements that Dr L raised with us. These elements are:

- whether it was reasonable for the CQC to suggest barristers investigate FPPR matters:
- whether the CQC should have passed Dr L's concerns about FPPR onto Trust F immediately after January 2015;
- the CQC's process for considering the Barristers' draft report in relation to FPPR and if Trust F were in breach of FPPR; and
- the CQC's handling of Dr L's comments on the Barristers' draft report.

<u>The CQC's suggestion that barristers investigate a potential breach of FPPR</u>

78. Dr L told us that it was inappropriate for the CQC to suggest using barristers when his allegations related to patient safety and safe-guarding. Regulation 5 (paragraph 11) sets out that it is the provider's role to assure Regulation 5 is met, not the CQC's role. The CQC's role is to regulate providers in their handling of Regulation 5 and their policy and guidance is not prescriptive about how providers should investigate matters. The CQC's approach (paragraphs 13 and 14) considered whether providers had a robust process and if they had reached a reasonable decision.

79. We accept that the CQC's role was to consider whether the process followed by Trust F was appropriate. We agree with the CQC that this would include a provider taking account of their legal responsibilities for Regulation 5 and that appointing barristers is consistent with that. We also accept the appointment of the Barristers ultimately rested with Trust F, not the CQC, and that the CQC specifically told Trust F they were not prescriptive about the process used for obtaining assurance for FPPR (paragraph 30). Therefore, we accept the CQC's account that they were trying to be helpful to Trust F at a time when handling of FPPR matters was still in its infancy. With these factors in mind, we consider that the information the CQC passed to Trust F about barristers being appointed in other FPPR cases was reasonable.

<u>Timeliness of the CQC passing Dr L's allegations to Trust F/the Barristers</u>

80. Dr L said that the CQC failed to pass on his allegations about FPPR and that they failed to tell him this. The CQC have told us that there is a more proportionate way to report this issue and that they consider other parties are also culpable (paragraph 73). Our role is to look at processes and procedures. Therefore we have taken account of the relevant benchmarks which include the standards the CQC set for themselves on such matters. The actions of other parties become relevant if we find maladministration and proceed to consider the impact arising from any mistakes. When considering Dr L's allegation in January 2015 in relation to the CQC's administrative processes, we would expect the CQC to take account of their policy and guidance. The CQC's policy and

guidance said that if the CQC were intending to progress a third party FPPR allegation onto a provider, the director would be asked to give consent so they could pass the information of concern to the provider and that the CQC may still consider passing the allegation if consent was not received (paragraph 14). Further, in relation to our Principles (paragraph 9) *'getting it right'* we would expect the CQC to act in accordance with their policy and guidance and when they decide to depart from their own guidance they should record why.

81. Whilst the CQC asked Trust F what action they were taking about the anonymous letter (paragraph 27), the evidence shows that the CQC failed to apply any part of their 2014 and 2015 Guidance in relation to sharing Dr L's information with Trust F. The CQC did not seek consent from the Chief Executive, or from Dr L, to pass on Dr L's concerns to Trust F in relation to their concerns about data protection. The CQC also failed to consider whether they should pass on any information to Trust F – in summary form or otherwise – from Dr L's letter of 11 January 2015. Whilst the CQC told us (paragraph 73) that, essentially, they were content Trust F had Dr L's information in January 2015 because Trust F had the anonymous letter and Dr L's book, we do not consider this was sufficient. Nor do we accept the CQC's suggestion that Dr L's compliment to the Inspection team in March 2015 about their handling of his timeline (paragraph 28) showed that they had considered the entirety of his submission. The evidence shows that, even by June 2015, the CQC were saying that they were unable to take a view on the large amount of supporting evidence from Dr L as they had not considered it (paragraph 33). In short, whilst the CQC provided us with a retrospective rationalisation of their decision on Dr L's submission, the papers show that the CQC simply failed to follow their own procedures or take any action. The CQC did not get it right.

82. Even when the CQC started acting on their responsibilities to share information of concern around FPPR from Dr L, the CQC failed to maintain a coherent approach. The CQC again failed to following their processes – they did not contact the Chief Executive to obtain consent to pass on Dr L's concerns to Trust F. Nor did the CQC discuss what information should be shared with Trust F. Instead, the CQC's records show that the CQC discussed another approach (sharing a list of documents held). However, their records showed that they then decided on the following day to send Trust F all the records they held (paragraph 39). There is no evidence that the CQC completed a consideration of the evidence provided by Dr L in accordance with their policy. Nor did the CQC record why they acted outside their approach. The CQC did not get it right. It was maladministration.

<u>The CQC's process for considering the Barristers' draft report and if Trust F were in breach of FPPR</u>

83. Dr L told us that he thought the CQC's process for considering FPPR for Trust F was not robust and that Trust F was in breach of FPPR. We would expect CQC to take account of its legislative duties around FPPR in relation to Trust F (paragraph 11) and its policy and guidance (paragraphs 13 and 14). The CQC told us that this would include whether Trust F had done a thorough job and reached a reasonable conclusion, which was rooted in evidence, proportionality and reasonableness (paragraph 16). In *'getting it right'* our Principles (paragraph 9) say public organisations should take account of relevant considerations and balance up the evidence. In being *'open and accountable'* we would also expect the CQC to maintain records of their activities and considerations.

84. The evidence suggests a lack of clarity about how the CQC were intending to reach a decision on Trust F's handling of FPPR. Initially, the FPPR Panel note of 30 September 2015 showed that the CQC were going to consider whether the Barristers' draft report addressed the CQC's concerns as set out in the CQC's letter to Trust F of 9 April 2015, and whether there was anything to suggest that the Barristers' draft report was unreasonable. In particular, the FPPR Panel said they had questions about whether Trust F complied with FPPR as they were interested in whether the Barristers had dismissed the W report for seemingly '*flimsy*' reasons. Dr L said he could not understand how the CQC had allowed the Barristers to dismiss the accepted and evidenced findings of the W report (paragraph 69). However, on 5 October 2015 the Director of Governance and Legal Services said the CQC should consider whether the deficiencies in the Barristers' draft report meant that Trust F had failed to comply with FPPR and questioned whether the issues in the CQC's letter of 9 April 2015 were fundamental to the issue of the Chief Executive's fitness. The absence of any further record of what the CQC did to reach a decision suggests the record of their internal discussion is incomplete.

85. There is, therefore, insufficient evidence to show the approach the CQC took. The CQC told us that '*unminuted*' discussions took place (paragraph 74) among the senior members of the FPPR Panel which considered the matters that the CQC could comment on. The same problem occurs in relation to Dr L's comments on the Barristers' draft report. We do not know what the CQC's thoughts were about Trust F and the Barristers' handling of Dr L's comments (paragraphs 54 and 55). This is because the CQC have been unable to tell us (paragraph 75) and did not record their consideration.

86. Documentary evidence of the CQC's rationale for closing the case on FPPR for Trust F is only provided by the Chief Inspector of Hospital's email of 9 October 2015, which said that there was insufficient evidence that the Chief Executive was responsible for failings at Trust H. The CQC should have recorded how they reached this decision and explained how much impact the Trust's/the Barristers' consideration of Dr L's comments had on their decision to close the FPPR matter. The CQC's failure to do so was not open and accountable.

87. The lack of detailed records about how the CQC reached their decision on Trust F's approach to FPPR is not the same as saying that the CQC's decision itself was flawed. The evidence shows that the CQC were having discussions about how to approach matters, as shown by FPPR Meeting minutes on 30 September 2015 and the Director of Governance and Legal Services' email of 5 October 2015. For these reasons, we accept that the CQC were considering and debating the case.

88. Further, we accept from the Director of Governance and Legal Services email of 5 October 2015, that the CQC were focusing their consideration on whether the Barristers' draft report provided assurance on the Chief Executive's fitness in relation to FPPR. This approach appears consistent with Regulation 5 and the CQC's guidance (paragraphs 11 and 14). We know also from the Chief Inspector of Hospital's email of 9 October 2015 that it was not accepted that the Chief Executive was responsible for failings at Trust H. Therefore, there is no evidence to suggest that the CQC decision was not properly made.

<u>The CQC's handling of Dr L's comments on the Barristers' draft report</u>

89. Dr L said that the CQC ignored his comments on the Barristers' draft report. The legislation and the CQC's guidance are silent about what information should be

communicated to third parties about the FPPR process in relation to their handling of it. They reflect that the CQC's regulatory oversight for FPPR relates to the actions of providers (paragraph 11) and their relationship was not directly with the individuals providing them with concerning information. That said, our Principle, (paragraph 9) '*being customer focused'* says public bodies should be clear what individuals can and cannot expect from them and that if they make a commitment they should keep to it. In *'being open and accountable'* we would also expect the CQC to be transparent, ensuring information is clear, stating reasons for decisions and creating usable records. In acting *'fairly and proportionately'* public bodies should ensure that they listen to customers and ensure that their decisions are appropriate and fair.

90. The evidence shows that the CQC failed to properly coordinate their response to Dr L when handling his comments on the Barristers' draft report. Initially, on 13 October 2015 the Director of Governance and Legal Services told colleagues that the CQC were focused on Trust F's compliance with FPPR and that the CQC could not act as an intermediary between Dr L and the Barristers . The Director of Governance and Legal Services said that the onus was on Dr L to take his concerns up directly with the Barristers and Trust. We accept that the CQC's responsibility was to look at how Trust F handled FPPR, and not for the CQC to make a decision on FPPR directly. Therefore, it was consistent with Regulation 5 for the CQC to adopt this approach - that it was for Dr L to take up his concerns about the Barristers' draft report directly with the Barristers or Trust F. It would then have been for the CQC to consider how appropriately Trust F/the Barristers' dealt with Dr L's comments in relation to FPPR.

91. The problem occurred because the CQC did not tell Dr L this. Instead, their correspondence with him implied the opposite. On 15 October 2015 the CQC emailed Dr L to say that they *would* respond to his email about the Barristers' draft report sometime after 24 October 2015, '*once we have considered it in full*'. Dr L said this gave him the clear impression that the CQC would come back to him and that he could be secure in his understanding of the position he stated to them - that he had no need to contact the Barristers in relation to their draft report. However, despite the CQC's commitment to respond to Dr L, the CQC sent a letter to Trust F on 5 November 2015 which said the CQC did not accept Dr L's criticisms of the Barristers' draft report. In addition, the CQC recorded, internally, that they had decided that they would not be contacting Dr L in advance of Trust F's report being published (paragraph 61) without seemingly taking into account that they had already given him the clear impression they would. Therefore, the CQC were not clear with Dr L about their approach or their reasons for taking the actions they did. Dr L was entirely unaware of the CQC's approach. In short, the CQC's actions were not focused on the service user or open and transparent, but more importantly for Dr L, they simply were not fair. This was maladministration.

Injustice

<u>Failure to follow policy on passing on information to providers</u>

92. We found that the CQC failed to follow their policy and guidance in relation to passing evidence to Trust F in connection with Dr L's allegations about the Chief Executive. Dr L said that this failure meant that the Barristers' investigation took longer which caused him distress. Further, that he received abuse over social media from those who blamed him for the additional costs incurred by the Barristers following five month delay in the CQC passing his allegations to them. Dr L also said that he thought he was

being harassed by Trust F when they tried to contact him in June 2015, not realising they did not know about his allegations to the CQC.

93. There is no evidence to suggest that the course of events up to the Barristers being appointed in May 2015 would have changed, even if the CQC had passed Dr L's submission to Trust F in January rather than June 2015. This is because in April 2015 the CQC considered that the process used by Trust F was not robust enough to fully address the FPPR matters (paragraph 30). It is not clear that Dr L's submission would have impacted on the CQC's consideration of the process used by Trust F. However, on the balance of probability if the CQC had passed on Dr L's submission to Trust F earlier, the Barristers' investigation is likely to have finished earlier. We say this because the Barristers told CQC that they had needed to expand their TOR following receipt of Dr L's allegations and that it had increased the timeframe and cost of Trust F's investigation (paragraph 41). The Barristers originally said that they were intending to complete their investigation by August 2015 (paragraph 31). However, at the point that the Barristers became aware of Dr L's submission it was June 2015, one month after they had been appointed to investigate the FPPR matters (paragraph 31). Therefore, if the CQC had shared Dr L's submission with Trust F in May 2015, when the Barristers' were appointed, instead of June 2015 when they passed on Dr L's submission it is likely that the Barristers' would have known about it one month earlier. Although the CQC say that the Barristers' contacted Dr L within 21 days (paragraph 73) to arrange an interview with him, it does not change the fact that prime facie documentary evidence was not passed to the Barristers by the CQC until 26 June 2015. In addition, as Dr L's submission was eventually passed to the Barristers, we do not agree with Dr L (paragraph 68) that the delay had a bearing on the Barristers' decision-making. We accept that the slightly longer timeframe of around one month for completing the FPPR investigation would have caused Dr L upset, as would the distress of the CQC's handling of this matter.

94. We accept Dr L's account that he has received criticism for the cost of the investigation, and that this caused him distress. However, it is not entirely clear that the abuse Dr L received was about the possible *increased costs* arising from the CQC's failure to pass on information. The criticisms we have seen suggest that commentators were unhappy with the cost generated from the entire FPPR investigation, not just the increased costs. Dr L argued that the negative headlines in relation to the Barristers' investigation were based on the *increased* costs which were due to the CQC's failure to pass on his submission to Trust F. He suggests that in the absence of costs increasing, the negative headlines would not have been generated and would not have resulted in criticisms of him in public forums. We accept that is a possibility. However, we are mindful that Trust F had already told the CQC that they were unhappy with the resources being taken up by this FPPR matter (paragraph 29) in April 2015. This was before the CQC's failure to pass evidence had emerged. Therefore, we cannot say that the issue of costs would not have arisen between the CQC and Trust F and whether this would, or would not, have played out in the public domain. As Trust F published the Barristers' report, the issue of costs around the investigation may well have arisen. Therefore, Dr L may well have received negative feedback about financial costs regardless of the CQC's mistake.

95. In relation to Dr L's concern that he felt that he was being harassed by Trust F when they tried to contact him in June 2015 (paragraph 32), it seems to us that this scenario would have occurred regardless of maladministration by the CQC. It was not part of the CQC's policy or guidance to update Dr L about how Trust F was planning to progress

their consideration of FPPR. Therefore, even if the CQC had passed on Dr L's information to Trust F in January or February 2015, it is likely that he would still have felt harassed when Trust F tried to make contact with him about their investigation. That being so, it is difficult to see how action by the CQC could have avoided this scenario.

Lack of clarity in decision-making

96. We found that the CQC's decision to close the FPPR matter in relation to Trust F and the Chief Executive lacked clarity because they failed to explain or record their thinking on Trust F's compliance with FPPR or the Barristers' response to Dr L's comments. This does not mean that the CQC's decision on Trust F's compliance with FPPR would necessarily have been different in the absence of maladministration. It is possible that the CQC might have made the same decision if their administrative actions had been properly completed. However, regardless of the outcome, the CQC's decision would have had a clear audit trail. We accept that in the absence of this, Dr L will not feel confident in the CQC's decision on FPPR in relation to Trust F and the Chief Executive. This is an injustice to him.

Failure to communicate approach to Dr L's comments

97. Lastly, we found that the CQC failed to explain to Dr L how they would approach his comments in relation to the Barristers' draft report. Dr L said that this meant he was denied the opportunity to take legal advice in order to prevent publication of the Barristers' report. Dr L said publication of the Barristers' report by Trust F damaged his reputation through the negative press interest it attracted. Certainly, if the CQC had told Dr L about how they would handle FPPR matters before Trust F had published their report, Dr L would have had more time to make a decision about how to proceed.

98. In the absence of maladministration, the CQC would have told Dr L about their approach to his comments, as set out by the Director of Governance and Legal Services (paragraph 53). In particular, that it was for Dr L to take up his concerns about the Barristers' draft report directly with the Barristers/Trust F. We consider that this would have significantly improved Dr L's experience of dealing with the CQC. In particular, Dr L would have been given relevant explanations and information which would have enabled him to reach an informed view about what his next steps should be in relation to Trust F. We recognise that Dr L will consider that this prevented him from following up matters with Trust F in relation to their regulation of FPPR. With this in mind, we accept that there is a high likelihood that Dr L would have had more time to consider taking legal advice in advance of the Barristers' report being published in order to manage any risks arising from such a publication to him. We cannot speculate about how successful Dr L's attempts to block the Barristers' report would have been.

99. However, as a result of the CQC's maladministration we accept that Dr L was disadvantaged from considering steps that may have impacted on the either the contents or publication of the Barristers' report. He did not know that the CQC were not going to deal with Trust F/the Barristers' on his behalf, or that he would need to maintain communication with the Barristers, about the Barristers' report. These factors present a significant loss of opportunity for Dr L. In particular, that Dr L will feel that he could have prevented publication of the report and the negative comments that he received afterwards. We are unable to say if the events would have unfolded in the way that Dr L says, but we accept that Dr L lost the opportunity to attempt to achieve a different

outcome and he will never know how successful his attempts might have been. This is a serious injustice to Dr L.

100. As for Dr L's concerns about the impact on his reputation, we have seen evidence of negative comments about him on social media (paragraph 71). We can see that this is distressing for him. However, we cannot say whether the CQC's consideration of FPPR would have changed in relation to Trust F. Nor can we say whether more notice of publication for the Barristers' investigation report would have allowed Dr L to present a successful legal challenge. Therefore, we cannot definitively say that the outcome in relation to Dr L's public perception would have been different. That said, we recognise that Dr L will consider this a huge loss of opportunity for a different outcome - this is an injustice to him.

Recommendations

101. In considering recommendations, we have referred to our Principles for Remedy. These state that where maladministration or poor service has led to injustice or hardship, the public body responsible should take steps to provide an appropriate and proportionate remedy. They also say that public organisations should seek continuous improvement, and should use the lessons learnt from complaints to ensure that maladministration or poor service is not repeated. Finally, our principles also state that public organisations should 'put things right' and, if possible, return the person affected to the position they would have been in if the poor service had not occurred. If that is not possible, they should compensate them appropriately. In order to determine a level of financial remedy, we review similar cases where similar injustice has arisen and refer to our Scale of Severity of Injustice process.

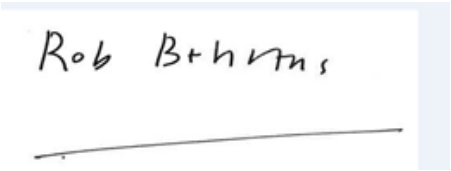
102. We have made no consideration for financial compensation as Dr L has specifically declined that. In addition, we make no recommendation about the clarity of the CQC's decision making because they have addressed that in relation to a separate, recent, investigation we completed about FPPR[14]. Further, the CQC has changed their policy and guidance with regards to passing on the totality of evidence they receive from third parties expressing concern about FPPR (see annex). Since publishing our investigation, we are also conscious that a number of recommendations have been made by the Kark Review, with subsequent actions being taken forward by Baroness Harding, while a follow-up inquiry has also been held by the Health and Social Care Select Committee. This background is reflected in the approach taken in our second recommendation.

103. In order to remedy the remaining injustice we have identified that resulted from CQC's maladministration, following the final report, CQC should apologise to Dr L within two weeks for the injustice (distress and loss of opportunity) their actions have caused him and evidence to us that this has happened.

104. Following our findings in this investigation about the injustice in this case, as well as the findings from our previously published investigation, CQC should also within three

[14] The CQC say that each FPPR referral sets out clearly a running commentary of the matters discussed by the FPPR Panel, any decisions made by the Panel and any further action required for that referral. At the point of closure, the meeting record also details all the information considered as part of that referral to support the outcome.

months conduct a review of its policies or procedures around communication about its role in relation to third parties and FPPR. This should include how individuals can expect to be treated with a view to considering what third parties should expect from CQC when raising concerns and to ensuring that that they are clear about what they can expect from the CQC when raising concerns. The CQC should consider whether it should consult any other bodies such as the National Guardian, about any proposed changes prior to the conclusion of the Review. The CQC should report the outcome of their back to us, and consider whether it should also be communicated to other interested parties such as Baroness Harding and the Chair of the Health and Social Care Select Committee, which has been conducting a follow up inquiry on the Kark Review.



Rob Behrens
Ombudsman and Chair

17 July 2019

Annex

On 19 January 2018 CQC updated its guidance on FPPR[15]. It included:

- When CQC receive information about an individual director, they may need to convene an FPPR Panel. If the FPPR Panel considers that this needs following up, they will ask the person providing the information for their consent to share it with the relevant provider. In exceptional cases they will progress the allegation to the provider without consent of the person;
- *'Ultimately, a provider should determine which individuals fall within the scope of the regulation, and CQC will take a view on whether they have done this effectively.'*
- There may be occasions where there is a dispute about the relevant facts, and the provider's investigation should seek to ascertain the facts of the case including taking account of people who have spoken up. This may involve seeking external and independent help by the Trust. Hearsay evidence could be relevant but providers should be cautious before making decision solely based on hearsay evidence and should carefully balance evidence where there is a conflict of evidence;
- CQC said that misconduct means *'conduct that breaches a legal or contractual obligation imposed on the director. It could mean acting in breach of an employment contract, breaching relevant regulatory requirements (such as mandatory health and safety rules), breaching the criminal law or engaging in activities that are morally reprehensible or likely to undermine public trust and confidence.';*
- CQC said that mismanagement was, among other things, *'Transmitting to a public authority, or any other person, inaccurate information without taking reasonably competent steps to ensure it was correct. …Failing to model and promote standards of behaviour expected of those in public life, including protecting personal reputation, or the interests of another individual over the interests of people who use a service, staff or the public.';*
- CQC said that providers should reach their own decisions as to whether an alleged breach met the threshold of serious misconduct or serious mismanagement. CQC said that serious misconduct differed from mismanagement as one single incident of misconduct could amount to serious misconduct. CQC emphasised that a breach of FPPR would require any misconduct to be serious. CQC gave examples of this which included fraud or theft, criminal offence, bullying, victimisation of staff, deliberately transmitting information known to be false and disregard for appropriate standards of governance including undermining due process.

[15] https://www.cqc.org.uk/sites/default/files/20180119_FPPR_guidance.pdf