

PART 9

FITNESS TO PRACTISE: ADJUDICATION

Question 9-1: Should the statute require the regulators to ensure that they establish a structure which is compliant with Article 6 of the European Convention on Human Rights without taking into account the role of the higher courts?

- 9.1 A significant majority agreed that the statute should require Article 6 compliance without taking into account the role of the higher courts.¹ For example, the Optical Confederation thought that the statute:

should require that the structure of adjudication across all the regulators is Article 6 compliant and there should be clear separation of investigation and adjudication to ensure public and professional confidence.

- 9.2 The Health and Care Professions Council reported that it is currently reviewing its structures to ensure “internal” Article 6 compliance. It stated:

We were the first regulator to put its panels at “arm’s length” and end the practice of Council members sitting as panellists. Similarly, we have always respected the concept of “equality of arms” and ensured that lawyers who regularly appear as presenting officers in fitness to practise cases are not involved in policy development or the training of panellists. We have also never had any form of review or “sign- off” arrangements for individual panel decisions, recognising that any such process would undermine their independence and impartiality.

- 9.3 The Association of Regulatory and Disciplinary Lawyers criticised the relevant jurisprudence which allows for “rescue by appeal”. It said:

We do not regard this as an appropriate response to procedural defects in a mature fitness to practise jurisdiction. Indeed, from the early days of the Human Rights Act the courts have not advocated reliance on “rescue by appeal” as an answer to non-compliance: see Lord Cooke in 2001, “a disciplinary system in which a hearing satisfying Article 6(1) could be secured only by going as far as the Privy Council could not be commended”. Although we accept that due to the regulators’ significantly improved Article 6 compliance in recent years, “rescue by appeal” does not feature often in the modern appeals, it is still available as an argument. The statutory provision suggested by the joint Commissions would appropriately eliminate such an option.

- 9.4 Charles Russell LLP argued that ensuring hearings comply with Article 6 is crucial because, for the majority of its pharmacist clients, an appeal to the higher courts is not a realistic possibility “due to the legal costs they will incur

¹ Of the 192 submissions which were received, 60 expressed a view on this question: 49 said that the statute should so require, 10 disagreed, whilst 1 held an equivocal position.

(particularly if they lose)". RadcliffesLeBrasseur also argued this would "reduce the number of challenges to first instance decision making". Optometry Scotland further noted the potential efficiency savings if fewer cases were referred to the higher courts.

- 9.5 The Administrative Justice and Tribunals Council said that it "recognises the difficulty of specifying this in the statute", but that it:

would welcome a requirement for regulators to establish their own Article 6 compliant structures, perhaps with guidance being issued on the sorts of issues to be considered and taken into account.

- 9.6 An individual consultee (Walter Merricks) broadly agreed that the role of the higher courts should be excluded when considering Article 6 compliance, but stated that:

If the regulators' proceedings are self contained, it is reasonable to ask whether it is then necessary to maintain a full right of appeal on fact and law by way of re-hearing – without any requirement of leave ... It would be relevant to look at the volume of appeals and the burdens that these place on the higher courts. One option would be to abolish the right to appeal. The scope of judicial review encompasses decisions that have been made where there has been an error of law, so challenges on law can be accomplished through that route. I would question whether an appeal on fact should be permitted.

- 9.7 The Department of Health, Social Services and Public Safety for Northern Ireland supported the inclusion of a statement requiring Article 6 compliance.

- 9.8 However, a number of consultees disagreed that the statute should require Article 6 compliance. The General Medical Council stated that compliance is already secured through the establishment of the Medical Practitioners Tribunal Service and a right of appeal. Furthermore, it stated:

Although we believe that fitness to practise procedures should reflect best practice, the inclusion of requirements in the statute in relation to Article 6 over and above the role of the higher courts is likely to lead to protracted arguments at hearings that will cause delay and increase costs.

- 9.9 Similarly, an individual consultee (Anonymous) thought that:

Current arrangements where regulators put panels at arms length from the Council etc should be sufficient to ensure compliance with Article 6. It would be costly, unnecessary and disruptive to include in statute requirements that might suggest further independence from that currently applying is needed.

- 9.10 The Nursing and Midwifery Council felt that a statement requiring Article 6 compliance "will add nothing in terms of the protection of human rights", especially since "there is no proposal that the rights of appeal to the higher courts are removed and no proposal for a complete separation of functions, along the lines of the Office of the Health Professions Adjudicator." The Council noted that

Article 6 will apply to the other aspects of its adjudication processes. Furthermore, the Council considered that:

There is though a serious risk that it will involve the regulators in protracted and potentially costly and disruptive legal arguments about the nature of their adjudication structures, which will only result in resources being deflected from their work in protecting the public.

9.11 The Department of Health disagreed that the statute should require Article 6 compliance since this would, in effect, amount to “gold-plating” and would go beyond the requirements of the European Convention on Human Rights.

9.12 The Scottish Government commented that the regulators’ systems are already Article 6 compliant. It was “unsure regarding the effect of the proposals” and did not consider that “additional steps or safeguards are necessary”. It went on to say:

If the primary aim of explicitly stating that compliance with Article 6 is required is to ensure that the various requirements of procedural fairness have been met, there may be benefit in setting these out in the new statute. However we do not consider this to be essential and are concerned that the regulators could look upon any criteria specified as a checklist rather than minimum standards and consider these rather than looking more closely at the rights guaranteed by the Convention.

9.13 The Medical Protection Society argued that:

Given that each case is fact sensitive in terms of whether there has been Article 6 compliance, it follows that any structure would have to be very general and widely drawn such that it may only have limited application.

9.14 The General Chiropractic Council stated that it is “required as a matter of law to comply with Article 6 ... so statute telling us to comply with the law seems to us to be unnecessary”.

9.15 Some consultees felt that a better alternative would be for the Professional Standards Authority to monitor the regulators’ compliance with Article 6. The Law Society of Scotland took the view that “measures and procedures should be adopted by each regulator in order to ensure Article 6 compliance”, rather than reliance placed on statements in the statute.

Question 9-2: Should the new legal framework ensure the separation of investigation and adjudication, and if so how?

9.16 A majority agreed that the new legal framework should ensure the separation of investigation and adjudication.² Of those who specified how this should be

² Of the 192 submissions which were received, 59 expressed a view on this question: 43 said that the new legal framework should ensure separation, whilst 16 disagreed.

achieved, a majority felt that there should be a separate adjudication body.³ For example, the Association of Regulatory and Disciplinary Lawyers described as a source of regret the demise of the “wholly independent” Office of the Health Professions Adjudicator. Similarly, the Patients Association stated that:

The Office of the Health Professionals Adjudicator had the potential to be a truly independent adjudication function. Its abolition rather than development is disappointing, but we believe that the regulators should now aim to provide as independent an adjudication procedure as possible.

- 9.17 The Professional Standards Authority argued that separation will not be achieved following the abolition of the Office of the Health Professionals Adjudicator, but that:

The legal framework should do as much as possible to ensure public confidence in the overall process by separating the investigative and adjudicative functions where possible. If the Medical Practitioners Tribunal Service (MPTS) were to offer its adjudicative services to other regulators that might assist in establishing its credibility as separate from the General Medical Council. It may be difficult for the Council to demonstrate convincingly that the MPTS is operationally independent of it unless it provides further clarity about the governance arrangements and, possibly, gives the MPTS control over its own budget.

- 9.18 An individual consultee (Walter Merricks) argued that “it is unjust that doctors should have access to a more independent process while other professionals do not”. Coventry and Warwickshire Partnership Trust said that:

A single adjudication provider would be best understood by the public and therefore an extension of the General Medical Council proposals for this may be the best to take forward, although there would need to be consideration given to the costs.

- 9.19 The Scottish Social Care Council also thought that the “separation of adjudication and investigation can only be achieved fully by establishing an adjudicating authority, with a separate legal identity”.

- 9.20 However, the Medical Defence Union also expressed the following concerns:

The General Medical Council’s Medical Practitioners’ Tribunal Service may be one way of achieving separation of adjudication that is acceptable to all parties, though it does not provide complete independence from the regulator. Such a model may be too expensive for smaller regulators who will need to consider other arrangements, for example, merging or combining with one or more other regulators to provide an adjudicatory function.

³ Of the 192 submissions which were received, 30 expressed a view: 18 supported a separate body, 6 said that separation could be achieved through the use of internal committees, whilst 6 said that the matter should be left to the discretion of the regulators.

- 9.21 The Medical Protection Society suggested that separation should be achieved by:
- (1) the adjudicating body being accountable to Parliament rather than the regulator;
 - (2) the independent appointment of panellists to the adjudicating body;
 - (3) an independent audit of the adjudicating body's decisions; and
 - (4) the operational separation of investigation.

9.22 However, not all consultees agreed with a separate adjudication body. The British Association for Counselling and Psychotherapy felt that such a body “may not be fully cognisant of the peculiarity and specifics of the regulated profession under scrutiny”.

9.23 The Scottish Government considered that “the case has not been made to have an entirely separate body for adjudication from investigation” and that the Medical Practitioners Tribunal Service would introduce a high degree of independence into the adjudication of fitness to practise cases:

Whilst we accept that it is unlikely that most of the regulators would have the available resource for such a service, it is possible that the General Medical Council's service could be used by the other regulators in the future in the interests of promoting efficiencies, consistency, cost savings and economies of scale.

9.24 The General Social Care Council argued that:

The legal framework (either through rules or primary legislation) should clarify lines of accountability between panel members and officers of the Council, set out the appointment and appraisal arrangements for Panel members and confirm the status of guidance issued to panel members (for example indicative sanctions guidance). The Commission should be particularly aware of the opportunities for officers to place pressure on Panel members through appraisal and appointments and through this to compromise their independence.

9.25 The Professional Forum of the Pharmaceutical Society of Northern Ireland felt that separation was already achieved in Northern Ireland, where the inspectorate is based in the Department of Health, Social Services and Public Safety and adjudication is provided by the statutory committee of the Society. The Department of Health, Social Services and Public Safety for Northern Ireland agreed with separation and stated “this already pertains in Northern Ireland (pharmacy)”.

9.26 The General Chiropractic Council felt that the statute should be enabling and that it should be left to the regulator “to ensure the necessary separation to satisfy the European Convention”. The General Dental Council expressed a similar view, and the General Osteopathic Council agreed that “there should be flexibility for the regulators to determine how this separation is achieved in practice”.

- 9.27 Many argued that a lack of institutional separation was less troubling than the lack of good panel members, and suggested that a robust appointments process was crucial. The Health and Care Professions Council felt that a better approach would be to focus on the appointment process for panel members and prohibit them from sitting on cases that they have already considered at a previous stage. The Department of Health argued that the new legal framework should allow the regulators to demonstrate separation of investigation from adjudication through the creation of a “quasi-independent function within the organisation with responsibility for selecting, training and providing guidance to panellists”.
- 9.28 UNISON said that the deployment of panel members, as well as their appointment, was relevant:

The new legal framework should emphasise that the final determination of an allegation at a hearing should be only be carried out by those who have not been party to any of the preliminary proceedings that have preceded this, and that all material, including witness statements should be reviewed to ensure the final hearing is human rights compliant.

- 9.29 The Medical and Dental Defence Union of Scotland agreed that there should be a separation of investigation and adjudication but did not consider it to be of “sufficient importance to the impartiality of the process that it needs to be enshrined in statute”.
- 9.30 The General Pharmaceutical Council felt there was a “compelling case” for further structural separation between investigation and adjudication but that it needs to be done consistently and jointly across the regulators.

Question 9-3: Should the statute allow for the option of the regulators’ adjudication systems joining the Unified Tribunals Service?

- 9.31 A small majority agreed that the statute should allow for the option of the regulators’ adjudication systems joining the Unified Tribunals Service.⁴ For example, an individual consultee (Melanie McDonald) said that “the long term objective of bringing fitness to practise proceedings within the First-tier Tribunal system under the management of the Ministry of Justice should be promoted”. The Department of Health, Social Services and Public Safety for Northern Ireland also answered the question in the affirmative.
- 9.32 The Administrative Appeals Chamber of the Upper Tribunal argued that the adjudication function should be transferred to the First-tier Tribunal (Health, Education and Social Care Chamber). It was also suggested that:
- There is a wider debate about the extent to which there should be entirely separate tribunals in Scotland, Northern Ireland and Wales even where the jurisdiction concerns reserved matters.
- 9.33 The First-tier Tribunal (Health, Education and Social Care Chamber) agreed:

⁴ Of the 192 submissions which were received, 46 expressed a view on this question: 27 said the statute should allow for this option, 14 disagreed, whilst 5 held equivocal positions.

The transfer to a clearly independent body satisfies the criticism of repeated public enquiries ... and is the only action that will act to fully restore, in the long term, public confidence in the regulation of health professionals. The reform of this area need not be incremental and seen as forced upon unwilling professions piecemeal as some form of dogged retreat from isolation. It is clearly within both the professions' and the public's interest that a truly independent body safeguards their standards.

9.34 It also argued:

The drive for greater efficiency can be met by a transfer to the First-tier Tribunal because the mechanism and systems for such appeals already exist; the Tribunal would need only to modify in a small way its administration to absorb the presently nine separate administrations dealing with fitness to practice matters, plainly that offers an ideal opportunity for efficiencies. Nor is it difficult to construct a model which would be of benefit to both the public and the professions who presently fund all nine administrations and their various panels. No doubt agreement could be reached for the professions to fund the tribunals at the present rate per type of case and that figure either discounted to the professions for the anticipated savings or a guarantee of inflation only cost increases.

9.35 It was argued that the First-tier Tribunal has amassed a great deal of particular health related expertise due to its existing jurisdiction over social workers, care standards and Primary Health Lists. It was also noted that many Tribunal members sit on their respective professional disciplinary bodies.

9.36 The Administrative Justice and Tribunals Council also felt that this option was:

The most efficient and appropriate arrangement, so that all fitness to practise adjudication systems can benefit from, and be consistent with, the experience of other analogous First-tier Tribunal jurisdictions.

9.37 Some consultees argued that a right of appeal to the Unified Tribunal Service would be more affordable for registrants.

9.38 The General Medical Council had no objection to the statute allowing for this option but stated it would not support the transfer of its own adjudication service. Several regulators expressed an interest in this option. The Medical and Dental Defence Union of Scotland felt this option would not be appropriate "where there is a considerable specialist volume of regulatory work, such as in the General Medical Council and the General Dental Council".

9.39 A number of consultees disagreed that the statute should allow for the option of the regulators' adjudication systems joining the Unified Tribunals Service. The British Medical Association argued that the Medical Practitioners Tribunal Service "should be allowed to become properly established" and felt that the Unified Tribunal Service would not have the same level of expertise. NHS Greater Glasgow and Clyde objected to the proposal on the basis that "the last thing you want is another layer of bureaucracy".

- 9.40 The Association of Regulatory and Disciplinary Lawyers said it could “see no advantage in permitting regulators to opt for joining the Unified Tribunal Service structures”. The Medical Protection Society also queried whether the proposal offered “any real advantage”. In addition to its principled objections, the Society objected to the proposal on the basis that “joining the Unified Tribunal Service would be a costly, complex and lengthy process”.
- 9.41 The Nursing and Midwifery Council felt that the Unified Tribunals Service “has a limited role in dealing with contested fact-finding decisions” and questioned “whether the skills needed for regulatory tribunal or panel work are comparable to those working in that more appellate environment”. Thompsons Solicitors felt that the Unified Tribunal Service is already “overburdened”.
- 9.42 The Royal College of Midwives argued that transferring all adjudication to the Unified Tribunals Service would lead to a rise in fees and be unaffordable for registrants. The General Dental Council argued that the transfer would raise significant devolution issues “because the legal system of Scotland is guaranteed to be separate”.
- 9.43 The Department of Health felt that any transfer of powers to the Unified Tribunals Service would involve “a complicated and lengthy process to establish the new system” and “the added value of a Tribunal Service led process of adjudication is also difficult to identify”.
- 9.44 A small number argued that this should not be a matter for Government to decide. For example, the UK-wide Nursing and Midwifery Council Lead Midwives for Education Group felt that this decision should be left to the regulators.

Provisional Proposal 9-4: The statute should give all the regulators a broad power to establish rules for case management.

- 9.45 All consultees who expressed a view agreed with this proposal.⁵ For example, Thompsons Solicitors said that it “would welcome case management processes being rolled out across all regulators”.
- 9.46 The General Optical Council felt that “procedural matters such as this ought to be left to the individual regulators” although it also expected that “there will be a degree of similarity” in how this is achieved by the regulators.
- 9.47 The Medical Protection Society argued that:
- To ensure fairness, case managers should be independent. Furthermore, there should be a mechanism for appeal or review of case management decisions. Any sanctions for non compliance with case management directions should be equal in force against both parties.
- 9.48 The Scottish Government supported the proposal but felt that there should be “greater consistency between the regulators and ... limited discretion in the

⁵ Of the 192 submissions which were received, 46 expressed a view on this proposal: 46 agreed.

interests of fairness, openness and transparency". It also suggested that the Professional Standards Authority should provide "detailed guidance and oversight".

- 9.49 The Nursing and Midwifery Council suggested that case management powers should include "sanctions for non-compliance, where appropriate, whilst recognising that the use of such sanctions may be less relevant in a regulatory context". This was supported by the Professional Standards Authority. Several consultees pointed to the importance of being able to cancel hearings in certain circumstances and to allow for some decisions to be made on the papers.
- 9.50 The Professional Standards Authority questioned whether this should be a duty rather than a power on the basis that there are no circumstances where case management would be inappropriate.
- 9.51 An individual consultee (Walter Merricks) expressed concern about how case management currently operates. He stated that:

Judicial case management is effective when the judge gives directions and then tries the case. The irony is that in the General Medical Council a case manager is not allowed any role in the hearing itself, and the chair of the panel is not permitted any role in case management: a sure recipe for ineffective case management. One can add to this the natural reluctance of a defence lawyer to pay any heed to case management requests from an individual appointed by the very body that is launching proceedings against that lawyer's client.

- 9.52 The Royal College of Nursing argued that an independent organisation should be responsible for case management. It argued that "the absence of case management (akin to directions hearings in the Second-tier Tribunal)" means that "frequently hearings will over run and significant delays can be experienced". It pointed to a recent case which was "adjourned part-heard on no less than three occasions and a decision on sanction is only expected at the fourth reconvened hearing date" and with no avenue for redress "other than perhaps the High Court on a costly abuse of process application".
- 9.53 UNISON felt that some existing case management arrangements are "so heavily weighted against the registrant that they prejudice their right to a fair hearing". For example:

The Health and Care Professions Council currently provide that the hearing bundle need be served on the registrant only 42 days before the hearing. This routinely consists of witness statements not previously disclosed and hearsay and other evidence that would be considered inadmissible by other regulators such as the Nursing and Midwifery Council.

The registrant is then given only 14 days to submit papers in response. This is clearly unacceptable, especially where significant new evidence is introduced. There is no forum in place to object to this other than the final hearing where an adjournment would have

serious financial and other detrimental implications, not least for the registrant.

Provisional Proposal 9-5: The statute should provide that the overriding objective of the Civil Procedure Rules – that cases must be dealt with justly – is made part of the regulators’ fitness to practise procedures.

9.54 A large majority felt that the overriding objective of the Civil Procedure Rules should be made part of the regulators’ fitness to practise procedures.⁶ For example, the General Medical Council noted that it is “currently pursuing inclusion of [the overriding objective] in the statutory changes to support the establishment of the Medical Practitioners Tribunal Service”. The Health and Care Professions Council felt that the overriding objective should be “provided for within statute as a clear statement of intent, purpose and belief”.

9.55 The Administrative Justice and Tribunals Council agreed generally with the proposal but argued that:

Since fitness to practise adjudication is more akin to a tribunal, rather than a court process, the procedural rules governing the new unified tribunal system might provide a more appropriate and directly relevant model than the Civil Procedure Rules.

9.56 It noted that the Tribunal Procedure Rules introduced an overriding objective to deal with cases “fairly and justly”, including an obligation on parties to co-operate with the Tribunal, which could be made part of the regulators’ fitness to practise procedures. The Administrative Appeals Chamber of the Upper Tribunal also supported the inclusion of the overriding objective of the Tribunal Rules.

9.57 The General Dental Council felt that the proposal would help standardise the regulators’ rules on matters such as evidence and case presentation, but noted that this would “be dependent also on the rules in the devolved administrations being compatible in these respects”.

9.58 However, some did not support the proposal. The Association of Regulatory and Disciplinary Lawyers felt it would add little “to existing fair trial principles” and “has the potential to provide another source of procedural argument as to meaning/scope etc, in addition to those under Article 6 and the common law”.

9.59 The Medical Protection Society argued that:

Regulatory and civil proceedings are completely different in terms of their purpose and objectives and as such should be independent of one another. Whilst some of the features of the civil overriding objective may apply to regulatory proceedings, others do not and so it would make no sense to import it as a whole. Given that Article 6, in effect, prescribes an overriding objective for regulatory proceedings we question whether this needs to be expressed in terms in the statute.

⁶ Of the 192 submissions which were received, 47 expressed a view on this proposal: 40 agreed, 3 disagreed, whilst 4 held equivocal positions.

9.60 The Medical and Dental Defence Union of Scotland was also not “convinced that the overriding objective of the Civil Procedure Rules” was the correct test. The Professional Standards Authority “was unclear what the overriding objective would add that is not already covered by the rules of natural justice and the Article 6 rights”.

9.61 The Nursing and Midwifery Council preferred the inclusion of a duty to “conduct proceedings expeditiously” because:

Our proceedings are not about balancing the interests of two litigating parties but about balancing the interests of the registrant against the need to act to protect the public or otherwise in the public interest. Rather, we consider that the statute should make explicit the duty of the regulator to act “in the public interest” and that this concept should include protection of the public, maintaining public confidence in the profession and maintaining public confidence in the regulator.

9.62 The Society of Chiropractors and Podiatrists agreed that cases should be dealt with justly, but that this “should not be at the expense of dealing with cases expeditiously”. It continued that “if cases are not dealt with expeditiously, that in itself is unlikely to be just”.

9.63 However, several consultees did not support a requirement that fitness to practise proceedings must be conducted “expeditiously” (as currently stated in the Health and Care Professions Council’s governing legislation). For example, the British Pharmaceutical Students’ Association felt this would encourage “a culture of rushed fitness to practice proceedings”. The Department of Health added that in its view any duty to act expeditiously would be unhelpful since it is already implicit in the existing duty of public protection and Article 6.

9.64 An individual consultee (David Bleiman) queried how a paramount duty would interact with the overriding objective. It was argued that fitness to practise panels “cannot always and everywhere place protection of the public above everything else”; for instance some decisions require significant weight to be given to the interests of the registrant, such as whether to proceed with a hearing in their absence. Thus, he argued that the paramount duty should be placed on Council members and staff, while panels should be subject to the overriding objective. Similarly, RadcliffesLeBrasseur argued that the paramount duty will have to be made subject to the overriding objective.

9.65 An individual consultee (James Kellock) argued that a panel’s ability to give directions would be strengthened by having legally qualified chairs.

Provisional Proposal 9-6: The statute should require each regulator to establish Fitness to Practise Panels of at least three members for the purpose of adjudication.

9.66 All consultees who expressed a view agreed that the statute should require each regulator to establish fitness to practise panels of at least three members.⁷ For

⁷ Of the 192 submissions which were received, 48 expressed a view on this proposal: 48 agreed.

example, the Professional Forum of the Pharmaceutical Society of Northern Ireland supported the proposal “for the purposes of balance and fairness”.

- 9.67 The General Medical Council agreed that in relation to the number of panel members, this should be “expressed as a minimum to allow the regulators to decide their own approach depending on volumes of hearings and resources”.
- 9.68 The Royal College of Nursing argued that “to exceed three panellists can be daunting for registrants and can lead to unnecessarily long hearings”. The Professional Standards Authority argued that “for the purposes of achieving consistency and driving efficiency across the sector” the statute should specify the number of panel members (rather than leaving it open to regulators to have panels of more than three members). It also argued that the proposal was not compatible with “the notion of regulators sharing adjudication expertise”.
- 9.69 The General Dental Council felt that the statute should require the regulators to make rules, but should not specify numbers because “there are some occasions when a single member panel could be appropriate and this should be left to the rules to provide for”. It also argued that the statute should provide for the eventuality of a panel losing a member part way through a case and allow the hearing to continue even though the requirement of a particular composition can no longer be fulfilled.

Provisional Proposal 9-7: The statute should: (1) require the regulators to establish a body which is responsible for all aspects of the Fitness to Practise Panel appointment process and which is separate from the Council; and (2) prohibit Council members and investigators from membership of Fitness to Practise Panels; and (3) require that each Fitness to Practise Panel must have a lay member.

- 9.70 The vast majority agreed that the regulators should be required to establish a body which is responsible for panel appointments, and Council members and investigators should be prohibited from panel membership.⁸

Appointments

- 9.71 The General Chiropractic Council agreed that a separate appointment process must be established but queried our use of the term “a body” since it is considering appointing a President for this purpose. Similarly, the General Osteopathic Council felt there needed to be flexibility to take account of the needs of the small regulators where “it may be appropriate to appoint an individual to carry out this process or to be able to commission the work from another organisation”.
- 9.72 The General Medical Council argued that while the appointment body may be operationally separate from the Council, “that body may in governance terms be accountable to the Council in relation to overall performance” and like the Medical Practitioners Tribunal Service may need to report periodically to the Council as well as directly to Parliament.

⁸ Of the 192 submissions which were received, 53 expressed a view on this proposal: 52 agreed, whilst 1 held an equivocal position.

- 9.73 An individual consultee (Walter Merricks) felt that one of the “great weaknesses in the panel system” is the absence of a judicial head of the panels (except at the General Medical Council). He stated:

Panellists having been appointed to be independent, they have no sense of allegiance or accountability. Incompetent panellists cannot be sanctioned or removed. Who actually sits on each panel is up to the regulator. It is as if the prosecution was able to select which magistrates should sit to hear a case.

So the independence of the system can easily be subverted by the regulator by not calling particular panellists to sit, or calling those they feel are likely to be most sympathetic to the regulator’s case.

On the other hand regulators, having made the appointments of their panellists, feel inhibited in communicating with them about anything other than mundane matters. And from the panellists’ point of view there is no one to whom they can turn to look for guidance or for performance feedback and no one who will be appraising them or calling them to account.

- 9.74 The Administrative Justice and Tribunals Council felt that the new appointing body should be based on the arrangements for the Judicial Appointments Commission. The United Chiropractic Association felt that professional panel members should be elected by polling the profession.

- 9.75 The Department of Health was not convinced that Councils should be required to set up a separate body for appointments and suggested that the regulators should have powers to make arrangements for panel member appointments with other regulators and organisations.

- 9.76 The Scottish Government supported the proposals but also did not agree that the Councils should be required to establish a body responsible for Panel appointments. It thought that “it is for each regulator to make arrangements for the recruitment and training of its panel members”, but went on to state that:

However, we do consider that efficiencies and consistency could be provided through partnership approaches and collaboration in relation to recruitment and retention of panel members, and that Memoranda of Understanding could assist with this.

Composition of the panel

- 9.77 Some argued that the statute should specify the balance between lay and registrant panel members. For example, the Association of Regulatory and Disciplinary Lawyers argued that “the numbers should not permit ... a lay majority decision”. The United Chiropractic Association contended that:

The current deference of the High Court to decisions of professional disciplinary tribunals renders illogical a requirement for a majority membership of lay panel members.

- 9.78 A number of consultees also suggested that panels should include a member from the same profession as the registrant. For example, the Guild of Healthcare Pharmacists said:

We would also seek another requirement that the panel be required to have a member with detailed understanding of the sector/specialty of practice of the registrant.

- 9.79 UNISON agreed that there should be a requirement “that one panel member must be from the same occupational group as the registrant”. Similarly, the Medical Defence Union argued that “one member of the panel must be of the same profession as the registrant”.

- 9.80 However, others did not support registrant membership. The Nightingale Collaboration argued that registrants should not be panel members since “any specialist knowledge required can best be obtained from appointed expert advisors or expert witnesses called and open to cross-examination”. Similarly, the Royal College of Midwives preferred the use of a “mutually agreed expert” who can “attest to how care in the circumstances of the case should be managed”. It felt that:

It is not appropriate as at present for a member of the Panel who is a specialist in community midwifery, for example, to provide information to inform fellow panel members on the care to be provided in a high tech delivery unit or vice versa.

- 9.81 The Nursing and Midwifery Council suggested that that fitness to practise panels “should always have more lay than registrant members” in order to achieve the “necessary degree, and appearance, of independent scrutiny”.

- 9.82 An individual consultee (Anonymous) thought that there “should be two lay members on each panel to achieve the necessary degree, and appearance, of independent scrutiny”.

- 9.83 The Professional Standards Authority felt that the statute should specify that – to maintain public confidence – there should be “parity between lay and professional members, and the chair of a panel should be a lay person”.

- 9.84 Others expressed concern about lay membership. The United Chiropractic Association felt that “lay representatives are often in reality professional tribunal members and their independence and impartiality is not always guaranteed”. The Administrative Appeals Chamber of the Upper Tribunal felt that there are now “very few truly lay members of tribunals” and instead members should be “expected to bring a degree of expertise, which in this instance would be in professional standards”. Furthermore, it argued that:

If there is appropriate lay membership at the investigation stage and if the Professional Standards Authority has the role proposed for it, we are not convinced that the size of the panel should be expanded to provide for a lay member who does not hold any health care or social care qualification.

- 9.85 Some argued for consistency across the regulators on this matter. An individual consultee (James Kellock) stated:

I think the public would not understand if one health care regulator were able to mandate lay majorities whilst another allowed a registrant majority. My view is that since the paramount duty emphasises the impact of the profession on the public ... that there should be lay majorities.

- 9.86 The Professional Forum of the Pharmaceutical Society of Northern Ireland felt that if an individual is a Council member at one regulator, they should not be eligible for membership of another Council's fitness to practise panels.

- 9.87 The General Medical Council felt that the requirement for panels to include a registrant and lay member should be dealt with in rules.

Legal chairs and legal assessors

- 9.88 Several consultees supported legally qualified chairs. For example, the Royal College of Nursing argued:

We would like to see a rule that the chair should be legally qualified. This would remove the requirement for a legal assessor at every hearing, which is costly for the regulator. The interventions of the legal assessor can be time consuming, as they have to repeat the standard advice that they will be giving to the Panels, without necessarily adding valuable insights. The involvement, engagement and value added of legal assessors in cases can be variable. We think that appropriately trained legal chairs would be confident enough to create more efficient hearings and advise the panel on the legal aspects relevant to the subject case.

- 9.89 However, the Health and Care Professions Council disagreed, stating that:

Chairs should be focused on ensuring hearings progress swiftly. They should not become drawn into legal disagreements, but maintain their focus on resolving disputes as quickly as possible. Legal assessors are able to talk to both parties in advance of proceedings starting and will often facilitate common points of opinion to be agreed. Because of their position of independence, they are able to intervene when appropriate, eg if questioning of witnesses is unnecessary or questions being put to witnesses are unfairly phrased. For a panel chair to be involved in these types of issues it could easily lead to impressions being made that their opinions were biased towards one party or another.

- 9.90 Similarly, Thompsons Solicitors supported the role of the legal assessor. It stated that:

The legal assessor is independent and assists the panel, regulatory body case presenter and registrant. It is particularly useful when, for example, a dispute arises between the parties, to have an independent person who can intervene without the involvement of the

Panel to see if a resolution can be found before taking the issue to the Panel.

- 9.91 The Professional Standards Authority suggested that there should be “procedural consistency” in the use of “legal advisers/assessors and specialist advisers to Panels”.

Provisional Proposal 9-8: Other than on those matters specified in provisional proposals 9-6 and 9-7, the regulators should have broad powers to make rules on the constitution of their Fitness to Practise Panels.

- 9.92 A large majority agreed that the regulators should have broad powers to make rules on the constitution of their fitness to practise panels.⁹
- 9.93 The General Optical Council felt that “consideration would also need to be given as to how this proposal would align with there being an independent adjudicator, if one were established”.
- 9.94 The Medical Protection Society agreed with the proposal but felt that “in order to ensure consistency, statute should lay down broad parameters for the constitution of Panels”. The Optical Confederation and NHS Greater Glasgow and Clyde both also supported a degree of consistency between the regulators.
- 9.95 The British Pharmaceutical Students’ Association believed that the regulators should be required to consult on rules about the constitution of fitness to practise panels.

Provisional Proposal 9-9: All regulators should be given broad rule-making powers on most procedural aspects of fitness to practise hearings.

- 9.96 A large majority agreed that the regulators should be given broad rule-making powers on most procedural aspects of fitness to practise hearings.¹⁰
- 9.97 Many argued that the statute should not preclude the possibility of a common approach across the regulators. The Administrative Justice and Tribunals Council went further and argued that “the ideal position would be to work towards the harmonisation of the procedural rules for fitness to practise hearings across all the regulatory bodies”.
- 9.98 The Scottish Government felt there should be “greater consistency between the regulators and ... limited discretion in the interests of fairness, openness and transparency”. It also suggested that the Professional Standards Authority should provide detailed guidance and oversight.
- 9.99 The Royal College of Nursing argued that the statute should “endorse the procedural safeguards of Article 6”.

⁹ Of the 192 submissions which were received, 45 expressed a view on this proposal: 44 agreed, whilst 1 disagreed.

¹⁰ Of the 192 submissions which were received, 41 expressed a view on this proposal: 35 agreed, 4 disagreed, whilst 2 held equivocal positions.

9.100 A small number disagreed with the proposal. For example, the Professional Standards Authority stated:

We do not consider that the benefits of the proposed flexibility outweigh the benefits that would be achieved by ensuring greater consistency in relation to the procedural aspects of the regulators' hearings. From our experience of reviewing all the final fitness to practise decisions made by all the regulators, we can see little value in the variations in the procedures that are currently in place.

9.101 UNISON said:

We do not agree that regulators should be given broad rule-making powers on most procedural aspects of fitness to practise hearings. As previously stated, consistency across regulators on generic issues is desirable and this is one of those areas.

Procedural rules have the potential to compromise the right to a fair hearing. Isolated development hinders the benefits of sharing good practice and learning points.

Question 9-10: Should the statute require that fitness to practise hearings must take place in the UK country in which the registrant is situated or resides?

9.102 A small majority felt that hearings should not be required to take place in the UK country in which the registrant is situated or resides.¹¹

9.103 The Nursing and Midwifery Council described its legal duty to hold hearings in the relevant UK country as “unhelpful, inefficient and costly” and argued that the duty:

does not allow for cases to be held where they would be most convenient for all involved, including vulnerable or disabled witnesses or registrants working away from home. For instance, under this proposal, an allegation relating to matters that occurred at a nursing home in Southern England would, if the registrant had moved to Scotland before the hearing, have to be held there.

9.104 The General Medical Council felt that the venue should be left to the regulators to decide “taking into account their individual requirements”. For example, the Council has recently moved its hearings to Manchester based on the need to increase the “efficiencies of its operation” and secure “the delivery of significant savings for registrants as a whole”. The General Osteopathic Council also suggested that a requirement to hold hearings in the relevant UK country would not be proportionate or cost effective for the smaller regulators.

9.105 The General Optical Council agreed, but said that it would “be interested in exploring avenues by which regulators could potentially collaborate or share resources to facilitate hearings in the devolved administrations”.

¹¹ Of the 192 submissions which were received, 54 expressed a view on this question: 17 said that the statute should so require, 29 disagreed, whilst 8 equivocal positions.

- 9.106 The Department of Health felt that it must be for the regulator to decide where to hold a hearing. It said that:

There may be reasons of practicality why a hearing can't take place in the country where the registrant works or lives. Indeed, in some cases this may be different and provided there are ways of ensuring fairness then rigid rules about where hearings should occur need not be necessary.

- 9.107 The General Dental Council opposed the proposal on the basis that the "requirement would be complex and expensive to administer".

- 9.108 The British Medical Association also argued "it would be difficult to gain a fair hearing in geographically smaller areas, such as Northern Ireland". Many professional bodies argued that the negative impact of the publicity associated with fitness to practise hearings is multiplied when hearings are held in Northern Ireland or Wales and this could have a long term detrimental effect on the livelihood of registrants whose fitness to practise is found not to be impaired.

- 9.109 Others pointed to further anomalies that could arise. For example, the Society and College of Radiographers argued that a registrant living in Northumberland might find it easier to get to Edinburgh rather than London, or that those living in North Wales may find Birmingham easier than Cardiff. The General Social Care Council argued that the primary consideration should be "ensuring reasonable access to justice and not the UK country in which the registrant is situated or resides".

- 9.110 However, many supported a requirement that hearings should take place in the relevant UK country. The Health and Care Professions Council described its existing legal duty in the following terms:

Hearings are not confined to Belfast, Cardiff, Edinburgh and London and we seek to take a flexible approach to hearing venues taking into account the finite resources available and the needs of those individuals who must attend a hearing. We consider that such an approach is fair and reasonable and accords with principles of open and transparent justice.

Registrants should not be prohibited from attending a hearing simply because they cannot afford to attend. Cost savings should not and cannot be a bar to ensuring fairness and justice.

- 9.111 The Royal College of Nursing argued that a requirement:

makes practical sense (in our experience most of the witnesses will live near the registrant), will enable the panels to have some local knowledge and intelligence, will limit the often exorbitant travel and accommodation costs being laid at the door of the registrants and will prevent regulators simply listing hearings for their own administrative convenience.

- 9.112 The Department of Health, Social Services and Public Safety for Northern Ireland argued that hearings should take place in the relevant UK country and felt that

such a duty “would provide local identity in a UK-wide framework but costs should be taken into account”.

- 9.113 An individual consultee (Jacqueline A Wier) thought that holding hearings in the UK country of the registrant “would enable both the registrant and members of the public access to hearings which would support accountability and transparency”.
- 9.114 Others felt there should be a presumption that a hearing will take place in the relevant UK country, but that this could be overridden if necessary. The Medical Protection Society argued that hearings “should take place as close as possible to the registrant’s place of residence, balanced against the convenience of the witnesses for both parties” and that “venue should not be decided in favour of the regulator on purely cost grounds”. UNISON argued that the duty should be to hold the hearing in the relevant UK country “unless the registrant consents to another location”.
- 9.115 The Scottish Government argued that, while this should be a matter for the regulator to decide:

Where possible hearings should be held in the country where the registrant is situated in or resides. There are also other factors such as where a registrant mainly works which could complicate satisfaction of this requirement. We consider that fairness is more important than the legal rules surrounding where the hearings should take place.

- 9.116 The Medical Defence Union felt that the regulators should be encouraged to consider whether there are “better and more effective ways to hold panel hearings that meet their needs and equally those of registrants and witnesses throughout the UK” but that this should not be a statutory requirement. The Association of Clinical Biochemistry suggested that “any reasonable special needs of both registrant and complainant should be accommodated to ensure the process is fair and transparent”.
- 9.117 Some consultees argued that the location of the hearing should be where the alleged incident took place or where the person practises rather than resides. The Wales National Joint Professional Advisory Committee queried what would happen if the registrant lives and works in different countries. The Patient and Client Council felt that hearings should be held in the locality of the patient. Bupa said that to hold hearings elsewhere than the country where the incident took place “would necessitate all witnesses travelling which is inequitable”.

Provisional Proposal 9-11: The statute should apply the civil rules of evidence to fitness to practise hearings. The relevant rules should be those that apply in the part of the UK in which a hearing takes place.

- 9.118 A significant majority agreed that the civil rules of evidence should apply to hearings.¹²

¹² Of the 192 submissions which were received, 43 expressed a view on this proposal: 36 agreed, 5 disagreed, whilst 2 held equivocal positions.

- 9.119 The General Medical Council stated that it currently operates its own rules of evidence but understood the benefits of harmonisation. However, it sought clarity on which particular aspects of the civil rules would be applied.
- 9.120 The Patients Association said that, “for the sake of procedural certainty”, the applicability of the civil rules of evidence “should be made clear to complainants”. The Department of Health, Social Services and Public Safety for Northern Ireland was generally supportive but stated “there are cases that could go through court proceedings and then further referred to the regulator, so we expect the court evidence would apply”.
- 9.121 The Association of Regulatory and Disciplinary Lawyers was divided on this issue. Some members felt that the use of the civil rules would be consistent with the procedural rules adopted by most of the health professional regulators and those outside the field of health care. Furthermore, they felt that “fitness to practise proceedings are not criminal proceedings”. However, other members disagreed that proceedings are essentially civil in nature, and pointed out that most of the relevant case law in this field is “based on criminal jurisprudence or criminal legislation as interpreted by the criminal courts”. In effect, to adopt the criminal rules “avoids the re-litigating of much settled law”.
- 9.122 RadcliffesLeBrasseur also argued in favour of the criminal rules, and noted that:
- The regulator has the power to prevent the registrant practising their chosen profession and earning their living. The criminal rules of evidence have been applied without significant injustice being identified. The criminal rules are very flexible.
- 9.123 The United Chiropractic Association also thought that the criminal rules should apply to:
- matters of such importance to a health professional as their vocation, their hard earned career and reputation (not to mention their living and ability to support their family and their employees).
- 9.124 The Medical Protection Society expressed concern about importing either the civil or the criminal rules. It stated:
- We submit that many of those rules are neither appropriate nor applicable to regulatory proceedings. For example, the Criminal Procedure Rules in relation to disclosure are far better suited to regulatory proceedings. Apart from anything else the Civil Procedure Rules do not contain any provision relating to unused material.
- 9.125 Some argued that the rules should not vary across the UK. RadcliffesLeBrasseur stated:
- We are a small country and health care professionals move from one country to another within the UK. Others practise on the boundary and will see and treat people from more than one jurisdiction. This is a recipe for uncertainty.

- 9.126 Similarly, the Royal Pharmaceutical Society of Great Britain felt that the rules should be “overarching and applicable across the UK and not [depend on] where a hearing takes place”.

Provisional Proposal 9-12: Fitness to Practise Panels should be able to admit evidence which would not be admissible in court proceedings if the admission of such evidence is fair and relevant to the case.

- 9.127 A large majority agreed with the proposal.¹³
- 9.128 Many, such as the Nursing and Midwifery Council, agreed on the basis that the purpose of professional regulation is public protection, rather than resolving civil disputes. In addition, the General Dental Council noted that “the civil rules of evidence in Scotland are different from those elsewhere in the UK” and therefore “the use of the formula ‘fair and relevant’ would be helpful because it would clearly apply to all jurisdictions”.
- 9.129 The General Optical Council supported the proposal but also expressed concerns about the late service of evidence “with the regulator not being provided with sufficient time to respond or being criticised for delay in the proceedings when asking for an adjournment”.
- 9.130 Several consultees suggested alternative formulations. The Medical Defence Union felt that – based on the General Medical Council’s rules – panels should not be able to admit such evidence “unless they are satisfied that their duty of making due inquiry into the case before them makes its admission desirable”. The Administrative Justice and Tribunals Council preferred the General Dental Council’s approach of such evidence being “helpful” and “in the interests of justice”. The Society and College of Radiographers felt that the Health and Care Professions Council’s wording should be adopted whereby evidence can be submitted if it is “fair, relevant to the case and in the public interest”. The Medical Protection Society argued that evidence should only be admitted if it is relevant, it is “in the interests of justice to hear such evidence”, there is “no prejudice to the registrant” and “all reasonable efforts have been made to procure and adduce the evidence in accordance with the usual rules of admissibility”.
- 9.131 The Royal College of Midwives noted the need to ensure “natural justice and that the evidence can be subjected to challenge”. NHS Greater Glasgow and Clyde also commented on the right of appeal.
- 9.132 A small number supported the proposal only on the basis that the starting point was inadmissible evidence in criminal rather than civil proceedings.
- 9.133 RadcliffesLeBrasseur disagreed outright with the proposal, and felt that:

There is a danger that cost efficiency and the convenience of witnesses may lead to a pattern of reliance on hearsay evidence or remote evidence giving. There should be a presumption that evidence that is contested should be given by the witness present in the Panel

¹³ Of the 192 submissions which were received, 50 expressed a view on this proposal: 44 agreed, 2 disagreed, whilst 4 held equivocal positions.

hearing room and that should only be departed from with good reason.

9.134 UNISON also disagreed, arguing that “a registrant’s right to a fair hearing enshrined in Article 6 would be compromised by this wording”.

9.135 The Royal Pharmaceutical Society of Great Britain said that it “would need more assurance and transparency as to what individual regulators would consider ‘fair and relevant to the case’”.

Provisional Proposal 9-13: The statute should require the civil standard of proof in fitness to practise hearings.

9.136 The vast majority agreed with this proposal.¹⁴ For example, the Health and Care Professions Council argued that the “the civil standard of proof is appropriate in a protective jurisdiction (such as the one in which the regulators operate)”. The General Medical Council, which has operated the civil standard of proof since 2008, reported no difficulties with the move from the criminal standard.

9.137 However, the Medical and Dental Defence Union of Scotland was concerned that the civil standard:

operates severely to the prejudice of registrants in serious cases where there are disputes of fact and where there are consequences which affect the livelihood of the practitioner. We do believe that some form of sliding scale remains the most appropriate and fair approach but acknowledge that traditional authorities are presently against this proposition.

9.138 The Wales National Joint Professional Advisory Committee expressed concern that “the civil standard of proof may not be sufficiently robust” and referred to “the likelihood of miscarriages of justice”. It argued that a sliding scale should be adopted “in line with the degree of seriousness of the matter under investigation”.

9.139 The Royal Pharmaceutical Society of Great Britain felt that:

The use of the civil standard of proof must be monitored by the regulator, Professional Standards Authority and Government to ensure a fair outcome for the public, and registrant. It should not be used to develop harsh regulation but more to be able to assess professional behaviour and judgment.

9.140 The Medical Protection Society thought that the civil standard “should only apply to the facts and not the decision on impairment”.

9.141 RadcliffesLeBrasseur argued that the move from the criminal to the civil standard was supported in Parliament “on the basis that it would make no difference because the civil standard was flexible”, only for that concept to be rejected by the House of Lords.¹⁵ It was further argued that the civil standard “is itself

¹⁴ Of the 192 submissions which were received, 44 expressed a view on this proposal: 40 agreed, whilst 4 disagreed.

¹⁵ *Re Doherty* [2008] UKHL 33, [2008] 4 All ER 992.

ambiguous because of the cases on the difficulty of proving on the balance of probabilities an inherent improbability”.

- 9.142 The Association of Clinical Biochemistry opposed the proposal “as the sanctions applied by the regulators can be far more punitive than those applied in a criminal court for issues of a similar seriousness”.

Provisional Proposal 9-14: The statute should require that all fitness to practise hearings must be held in public unless one or more of the exceptions in the Civil Procedure Rules apply.

- 9.143 A large majority agreed with the proposal.¹⁶

- 9.144 The Royal College of Midwives supported the proposal, but argued that:

the setting in which the hearings take place must ensure the safety of the registrant and that they cannot be subjected to threats in any form from the complainant or their supporters as has occurred to Royal College of Midwives members in the past.

- 9.145 However, opinion was divided over whether or not there should be a default position of private hearings for health and interim order hearings.

- 9.146 The Department of Health suggested that the regulators should determine when and why hearings should be in private and consult on their reasoning.

- 9.147 The Scottish Government agreed with the proposal but also stated:

However, where the regulators consider that hearings (or part thereof) should be heard in private, they must set out their reasons for such a request (eg publicity would defeat the object of the hearing, the case involves confidential information and publicity would damage that confidentiality, or a private hearing is necessary to protect the interests of any child, vulnerable person or protected party) and consult on any proposals.

- 9.148 The Health and Care Professions Council argued against such a default position because if there is a need to hold such a hearing in private one of the exceptions of the Civil Procedure Rules would apply. The Association of Regulatory and Disciplinary Lawyers agreed that the exceptions in the Civil Procedural Rules would include “not just the current rules relating to interim orders (interests of justice exception) and health (confidentiality exception)”, but also “the common law which currently underpins the decision-making on this topic”. An individual consultee (Walter Merricks) argued that other courts and tribunals “do not normally regard the fact that evidence will be given about a person’s state of health or a medical condition as requiring a hearing to be in private”.

¹⁶ Of the 192 submissions which were received, 44 expressed a view on this proposal: 34 agreed, 5 disagreed, whilst 5 held equivocal positions.

9.149 However, many argued for automatic private hearings. The Association of Clinical Biochemistry said that “as all health cases involve confidential information they should be held in private unless the registrant specifically states otherwise”.

9.150 The General Medical Council contended that automatic private hearings were necessary in health and interim order cases, otherwise registrants would be forced to apply for the hearing to be held in private and that:

The result will be that panels will have to consider such applications at the outset of hearings in a large number of cases. This in turn will lead to considerable delays at a time when the increasing hearing length is a concern and we are doing everything we can to reduce it.

9.151 In relation to health cases, it further argued:

Doctors, like patients, have a right to confidentiality about their health and the public right to information in such cases is outweighed by the need to protect vulnerable doctors who are unwell. As much of a hearing as possible should be heard in public so where a case involves a number of issues, only those issues that relate to a doctor’s health should be heard in private and the rest of the hearing should be in public. This reflects our current practice.

9.152 In respect of interim order hearings, the Council argued that:

The use of interim powers is critical to our effectiveness but we also recognise that they can be draconian from the point of view of the individual doctor. A referral may be made to an interim orders hearing on the basis of information that may, in some cases, be limited and nothing is proved at that stage. We believe that in balancing the rights of the public to information and the rights of individual doctors, hearings should be in private but any order made should be published.

9.153 The Medical Defence Union also argued that:

Hearing interim orders cases in public could result in professionals having their reputations damaged irreparably in circumstances where safeguards do not apply. There is no minimum period of notice and by their very nature Interim Order Panels deal only with serious allegations which are laid out in circumstances where, as noted, there is no proof of wrong-doing. These allegations will no doubt be of interest to the public and could make good copy for the media, but the legitimate public interest in these cases is limited only to the need to ensure that the public is protected through the use of interim orders if they are appropriate. There is no need to have a public hearing in order to achieve this.

9.154 Furthermore, it felt that the registrant is on “the back foot as far as any defence is concerned” and to be “in a position to have to argue at the same time for a private hearing cannot be considered in any way fair”.

9.155 Similarly, the Royal College of Nursing argued that:

The Nursing and Midwifery Council does not screen out many cases at the very early stages. The complaint may have been made maliciously. Often, interim order hearings are held about cases within a week or two of the complaint reaching the Nursing and Midwifery Council, and then those cases are dismissed at the investigating committee stage. The press frequently publishes information about interim order hearings. Accordingly, we see damaging coverage of nurses due to press coverage of interim order hearings before there has been any attempt to establish that there might be an arguable case at all. We would prefer a standard presumption that interim order hearings should be held in private unless there is a public interest in holding them in public.

9.156 An individual consultee (James Kellock) noted that interim order hearings:

are not fact finding hearings and the legitimate interest of the public in knowing if a practitioner is not allowed to practise is met by publicising the result where an interim order has been made.

9.157 RadcliffesLeBrasseur felt that the exceptions in the Civil Procedure Rules may not cover all cases where a private hearing is needed, such as:

where the registrant is the subject of a very damaging allegation where the mere publicity of the allegation may be unfair although it may not defeat the object of the hearing. An example is where allegations of child abuse are made against a paediatrician. The public interest would be served by making the transcripts and the outcome public if the allegations are proved.

9.158 The General Dental Council felt its current rules work well, whereby hearings are held in private where “the interests of the parties or protection of the private and family life of the respondent or any other person” require it or where “publicity would prejudice the interests of justice”. It was suggested that the use of the Civil Procedure Rules would lead to “increasing challenges and litigation for no substantial benefit”.

9.159 The Patients Association stated that:

All hearings should be in public except where to do so would be unjust or where the specific circumstances of the case outweigh the public interest in an open hearing, noting Article 8 This will ensure accountability in public and help ensure ongoing public confidence in the operation of the regulators.

9.160 The Nursing and Midwifery Council noted that its legislation allows certain cases to take place in “meetings rather than hearings, where no evidence needs to be called and there is no public interest in a hearing being held”. This was seen as a “useful provision” which enables the Council to deal with certain cases, such as uncontested interim order reviews, “more cost-effectively and efficiently”. However, an individual consultee (Anonymous) felt there should be a provision for such meetings to be held in public.

Provisional Proposal 9-15: The statute should provide that a witness is eligible for assistance if under 17 at the time of the hearing or if the Panel considers that the quality of evidence given by the witness is likely to be diminished as a result of mental disorder, significant impairment of intelligence and social functioning, physical disability or physical disorder. In addition, a witness should be eligible for assistance if the Panel is satisfied that the quality of the evidence given by the witness is likely to be diminished by reason of fear or distress in connection with testifying in the proceedings.

- 9.161 An overwhelming majority agreed with our proposal for when a witness would be eligible for assistance.¹⁷ For example, an individual consultee (Don Brand) supported the proposal, which he thought was “particularly important in relation to social work, where many of the people using services constitute ‘vulnerable witnesses’”.
- 9.162 The Medical Protection Society was “firmly of the view that all vulnerable witnesses should be protected”, and thought that this should be dealt with as part of the regulators’ case management procedures.
- 9.163 In addition, the Nursing and Midwifery Council suggested that panels should be given “residual discretion” to provide suitable arrangements “for any other witnesses in exceptional circumstances, where to do so is in the public interest”.
- 9.164 The General Social Care Council supported the proposal but also felt that “the terminology relating to the individual requiring assistance should be amended as this is currently outdated and offensive”. Others suggested that a more appropriate starting point might be the definition of disability in the Equality Act 2010 or a “vulnerable adult” in the Safeguarding Vulnerable Groups Act 2006.
- 9.165 The General Dental Council was unclear to what extent this proposal overlapped with other statutory requirements. It noted that:
- It appears, for example, that this would be a positive duty going beyond the requirement to make “reasonable adjustments” in equality legislation. It would be helpful if language was harmonised and the extent of any differences in intention made clear.
- 9.166 However, a small number of consultees disagreed with the proposal. South Staffordshire and Shropshire Healthcare NHS Foundation Trust (Social Care) argued that vulnerable witnesses should be given “the right to be appropriately supported” irrespective of any “considerations of whether evidence is diminished”. The General Medical Council argued that the definition of a vulnerable witness should be dealt with in rules rather than in the statute.
- 9.167 The Scottish Government argued that in relation to witnesses eligible for assistance, the statute would need to take into account the different legal requirements in the part of the UK in which the hearing is taking place. NHS Education for Scotland agreed that provisions in respect of vulnerable witnesses “should be based upon the law of the [relevant] country”.

¹⁷ Of the 192 submissions which were received, 47 expressed a view on this proposal: 44 agreed, whilst 3 held equivocal positions.

Question 9-16: Should the statute provide for special measures that can be directed by the Panel in relation to witnesses eligible for assistance, such as screening witnesses from the accused, evidence by live link, evidence in private, video recoded evidence, video cross examination, examination through intermediary, and aids to communication?

- 9.168 A large majority agreed that the statute should provide for special measures that can be directed by a panel in relation to witnesses eligible for assistance.¹⁸ For example, the British Psychological Society considered this to be “an excellent proposal and recommend[ed] that it be developed with appropriate safeguards for all parties”. Optometry Scotland was in favour of “any measure that might aid the process and permit a full, fair and balanced hearing”.
- 9.169 An individual consultee (Jacqueline A Wier) thought that:
- The ability to utilise technology to facilitate witnesses would help foster confidence in the professions through ensuring greater accessibility to hearings for witnesses. It would also support the robustness of the decision making process as a consequence of additional information provided through improved access to witness evidence.
- 9.170 The Association of Regulatory and Disciplinary Lawyers felt that the special measures should be stated in the statute, “there being no good reason why they should not apply consistently across the board”. An individual consultee (Anonymous) argued that the statute should also state expressly that the registrant or applicant cannot cross-examine relevant witnesses in cases involving sexual misconduct and sexual offences.
- 9.171 Several consultees felt that the statute should provide for such measures to be set out in rules. The Health and Care Professions Council argued:
- We are concerned that it might be unnecessarily restrictive for the statute to provide for special measures that can be directed by the Panel given the pace of societal and technological change.
- 9.172 The Medical Defence Union was not persuaded that the proposed level of detail needed to be included in the statute, but thought that it could be left to the discretion of the regulators. The General Dental Council suggested that there should be a “permissive power for the regulators to make rules on these matters”.
- 9.173 The General Osteopathic Council felt that “the actual measures appear to us to be matters of good practice which may be best dealt with in guidance rather than needing to appear in statute”. The General Medical Council argued that special measures should be a matter for case management using a general power in the rules and that the rules should provide for “the parties to seek directions from a case manager prior to the hearing”.

¹⁸ Of the 192 submissions which were received, 51 expressed a view on this question: 44 said that the statute should so provide, 1 disagreed, whilst 6 held equivocal positions.

- 9.174 The Administrative Justice and Tribunals Council suggested that the provisions of the Equality Act 2010 may also be applicable “in terms of the need to make reasonable adjustments to enable a disabled or vulnerable witness to give evidence”. RadcliffesLeBrasseur noted the proposal “is only for witnesses and not the registrant which is an apparent gap”.
- 9.175 The Scottish Government argued that the statute should provide for special measures “including but not limited to the examples in the question” and “these measures should be equally available to both parties”.
- 9.176 The Professional Forum of the Pharmaceutical Society of Northern Ireland said it would only support the use of special measures such as those proposed “in the most extreme circumstances”. The Royal Pharmaceutical Society of Great Britain said it was “conscious of potential cost implications”.

Provisional Proposal 9-17: The statute should require the regulators to establish a system for imposing and reviewing Interim Orders.

- 9.177 An overwhelming majority agreed that the statute should require the regulators to establish a system for imposing and reviewing interim orders.¹⁹
- 9.178 The Department of Health agreed with the proposals but also noted that in some cases it can take a regulator up to 30 days to impose an interim suspension order and that this was not conducive to public protection.
- 9.179 The UK-wide Nursing and Midwifery Council Lead Midwives for Education Group also commented on the time it can take regulators to impose interim orders. It said that:
- The decisions need to be immediate so any processes to be put in place need to take this into account. The decisions to impose an interim order cannot take weeks but should be 24 hours due to the seriousness of the referral.
- 9.180 The National Clinical Assessment Service also supported the “need for a speedy interim orders process to be in place for the protection of the public”.
- 9.181 The Scottish Government supported the proposal, but also considered that interim order hearings are an area where “the regulators could work together to establish common standards”. It also argued that the Professional Standards Authority should monitor “the reasonableness, appropriateness and consistency of extended orders”.
- 9.182 The General Medical Council suggested that the statute should enable the Registrar to carry out the review where the regulator’s proposals are uncontested in order to “maximise the efficiency of our procedures and avoid unnecessary hearings where there is no dispute between us and the defence”.

¹⁹ Of the 192 submissions which were received, 46 expressed a view on this proposal: 44 agreed, whilst 2 disagreed.

9.183 The Administrative Justice and Tribunals Council argued that rather than having separate arrangements for interim order panels these cases should be heard by fitness to practise panels.

9.184 An individual consultee (Melanie McDonald) argued that “the jurisdiction to make an interim suspension order should be transferred to the county court”. It was suggested that regulatory panels would retain powers to make interim conditions of practice orders, and have the right to review interim suspension orders made by the court at regular intervals and refer back to the court if there are grounds for the order to be lifted. It was noted that:

Interim orders at the moment are often made in cases where the allegations cannot properly be characterised as serious. Panels seem unable to distinguish between those cases of immediate and significant risk to the public and those – for example medication errors – where the risk can properly be contained by restricting the registrant's practice.

Provisional Proposal 9-18: The statute should require each regulator to establish panels of at least three members for interim order hearings (including a lay member). In addition, Interim Order panels must be appointed by a body which is separate to the Council and there would be a prohibition of Council members and investigators from sitting on such Panels.

9.185 The vast majority agreed that panels must consist of at least three members (including a lay member) and must be appointed by a body which is separate to the Council, and that Council members and investigators would be prohibited from sitting on panels.²⁰

9.186 The General Medical Council stated that:

As above for fitness to practise panels, the body responsible for all aspects of the interim order panel appointment process should be operationally separate from the Council and Council members should not play a role in the selection or appointment of panellists or the decisions of panels. However, that body may in governance terms be accountable to the Council in relation to overall performance.

9.187 The Professional Standards Authority argued that the statute should ensure a lay majority on interim order panels. It also sought clarity on what we meant by the term “investigators”. Other consultees – such as UNISON – felt that the statute should require that a panel shall include “at least one registrant member from the same occupation as the respondent”.

9.188 However, the Association of Regulatory and Disciplinary Lawyers said that it did “not believe that reviews of interim orders need a three member panel; they can be undertaken by the panel chairman without a hearing”.

²⁰ Of the 192 submissions which were received, 46 expressed a view on this proposal: 44 agreed, whilst 2 held equivocal positions.

Question 9-19: Should the statute prohibit Interim Order Panellists sitting on a Fitness to Practise Panel (either in relation to the same case or more generally)?

- 9.189 An overwhelming majority felt that the statute should prohibit interim order panellists sitting on a Fitness to Practise Panel in relation to the same case.²¹ A small majority disagreed that the statute should prohibit interim order panellists sitting on any Fitness to Practise Panel.²²
- 9.190 The Medical Defence Union agreed that there should be a prohibition in relation to the same case because interim order panellists:
- have been involved in making a decision at an earlier stage where, for example, evidence that may have been put before an Interim Orders Panel is not later put before a Fitness to Practise Panel.
- 9.191 Similarly, the General Medical Council argued:
- We do not believe that panellists are in the same position as professional judges whose training enables them to disregard knowledge obtained in previous proceedings where that knowledge is considered prejudicial. Panellists are not legally trained and, in order to ensure the process is fair for doctors, they should be protected from potentially prejudicial knowledge in the same way that juries are protected in the criminal justice system.
- 9.192 The Patients Association agreed that the presence of an interim order panellist on a Fitness to Practise Panel in the same case “may introduce undue prejudice, unintentional or otherwise, which may make rulings unsound.”
- 9.193 The Association of Regulatory and Disciplinary Lawyers suggested that a panellist who has sat on an Interim Order Panel should be prohibited from the Fitness to Practise Panel convened to hear the case, or any “linked” case. An example of a linked case was said to include one in which “the accused practitioners practised in the same practice, or the alleged modus operandi and experts to be called by the regulator are the same”.
- 9.194 The Department of Health, Scottish Government and the Department of Health, Social Services and Public Safety for Northern Ireland all agreed that interim order panellists should be prohibited from sitting on a Fitness to Practise Panel in relation to the same case.
- 9.195 Several consultees stressed that if a panellist has considered the case at an interim order hearing they should not be excluded from considering the case again at future reviews of any order given. It was also questioned whether this prohibition would extend to considering reviews of fitness to practise suspension

²¹ Of the 192 submissions which were received, 43 expressed a view on this question: 42 said that the statute should so prohibit, whilst 1 disagreed.

²² Of the 192 submissions which were received, 37 expressed a view on this question: 16 said that the statute should so prohibit, whilst 21 disagreed.

or conditions of practice orders. In addition, some argued that the statute should not prohibit interim order panellists from sitting on a fitness to practise panel:

There is huge benefit in having panellists with the ability to sit across all types of cases. Furthermore, from a purely practical basis, given the requirement to have a registrant from the same part of the register as the registrant concerned to sit on the panel, it would be logistically challenging to have such a prohibition and this could adversely impact upon the administration of justice.

- 9.196 Similarly, the General Osteopathic Council said that “maintaining a separate pool of panellists would not be economic or practical”. It continued:

The need to manage conflicts of interest between registrant panellists and parties to a complaint is also more difficult within a small profession and supports the need for a single larger pool of panellists rather than separate pools.

- 9.197 A small number of consultees disagreed with any statutory prohibitions on panel membership. For example, the Nursing and Midwifery Council stated this should be left to each regulator to determine. Coventry and Warwickshire Partnership Trust did not feel that either prohibition was necessary. It said that:

in other areas of health practice, there is an agreement that review panels and appeals panels may have one person from a previous panel sitting. This could be used with interim order panellists, and would allow for two of the three panellists to be new, and allow one member of the panel to be able to review the evidence previously considered and explain the thinking of the interim panel.

Provisional Proposal 9-20: The test for imposing an Interim Order should be that it is necessary to protect, promote and maintain the health, safety and well-being of the public (and maintain confidence in the profession).

- 9.198 A large majority agreed that the test for imposing an interim order should be that it is necessary to protect, promote and maintain the health, safety and well-being of the public (and maintain confidence in the profession).²³ For example, the Patients Association agreed with the proposal, on the basis that “it is proportionate but still subject to the paramount duty”.

- 9.199 Some suggested additional criteria. The General Medical Council felt the test should also include “the interests of the registrant” since:

On occasion, if a doctor feels under pressure to continue to work, it is helpful to be able to make an order so that they can get the help that they need in order for their health to improve.

- 9.200 Similarly, the Health and Professions Council suggested that an order may also be required “in the interests of the person concerned”.

²³ Of the 192 submissions which were received, 44 expressed a view on this proposal: 35 agreed, 6 disagreed, whilst 3 held equivocal positions.

- 9.201 The Association of Regulatory and Disciplinary Lawyers also argued that:
- The “public interest” ingredient is important, even if it is rarely used by the Interim Orders Panel, because it provides the flexibility that [the Panel] occasionally requires (see *Sandler v General Medical Council* [2010] EWHC 1029 where the doctor had committed criminal offences in connection with his completion of forms for cremation, which had no public safety element but suspension was deemed to be in the public interest).
- 9.202 The British Chiropractic Association was concerned that a test based on the need to promote and maintain public health, safety and well-being would be too broad and result in interim orders being too readily applied. The General Dental Council argued that the use of the word “well-being” would be too wide.
- 9.203 The Medical Defence Union disagreed with the proposal and preferred the test contained in the Medical Act 1983: “it is necessary for the protection of members of the public or is otherwise in the public interest, or is in the interests of a fully registered person”.
- 9.204 UNISON also preferred a different test and believed that:
- the Nursing and Midwifery Council guidance more accurately reflects the emergency nature of such orders, namely: “A committee must be satisfied that there is real risk of significant harm to the health, safety or well being of a patient, visitor or colleague if an order is not made. It is not enough for the Committee to take the view that such a step would be desirable”. This should be the only criteria, it is not appropriate to make a judgement on the “wider public interest” or “confidence in the profession”, especially when there has been no finding of fact.
- 9.205 The Optical Confederation argued that the test should be whether the registrant poses a risk to the public only, and that maintenance of confidence in the profession “should not be considered at this stage but is relevant at the substantive hearing when considering impairment”. Similarly, RadcliffesLeBrasseur argued that:
- The reference to maintaining confidence in the profession begs the question of whose confidence is being maintained The time for the regulator to mark its disapproval of conduct or to set standards is after a fact finding hearing and the Interim Orders Panel expressly does not make such findings.
- 9.206 The General Osteopathic Council agreed that “the types of issues that require an interim order are such that they are solely about public protection rather than maintaining confidence”.
- 9.207 However, an individual consultee (James Kellock) did not think that the public would understand:

why a registrant convicted of serious dishonesty was not susceptible to being subject to an interim order, which would be the consequence of limiting the test to the first part of the proposal.

Provisional Proposal 9-21: On all procedural matters in relation to Interim Order hearings (except for those specified in provisional proposal 9-18) the regulators should have broad rule-making powers.

9.208 An overwhelming majority agreed that the regulators should have broad rule-making powers on procedural matters in relation to interim order hearings.²⁴ For example, the Patients Association agreed that regulators should have powers “subject to the paramount duty”, and RadcliffesLeBrasseur supported the proposal “subject to the application of the overriding objective”.

9.209 The Medical Defence Union agreed with the proposal but also argued that:

The statute should retain the current requirement for the regulator to apply to the court to extend an order beyond the statutory period. This is a helpful safeguard that encourages regulators to ensure they investigate promptly and it should be retained.

9.210 Some consultees felt that the statute should impose greater consistency. The Health and Care Professions Council pointed out that it has no specific procedural rules that relate to interim order hearings. Instead, all such hearings are held in line with the relevant rules of procedure relating to each of the practice committees – Investigating, Conduct and Competence, or Health. The Council also argued that the regulators should be required to make rules on the following matters:

- (1) the criteria for review hearings (including timescales and the availability of new evidence);
- (2) the powers of the Panel;
- (3) the time period of orders (for example 18 months) and renewals;
- (4) the rights of the person concerned to appear before the Panel;
- (5) the rights of representation; and
- (6) the process of notification.

9.211 In addition, the statute should retain the requirement for the regulator to have to apply to the court to extend an order beyond the period initially set. An individual consultee (Anonymous) also suggested that the statute should state maximum periods for interim orders of 18 months and regular reviews.

9.212 The Royal College of Nursing suggested that the statute should clarify that while “no final findings of fact are to be made and so the decision has to be based on

²⁴ Of the 192 submissions which were received, 41 expressed a view on this proposal: 38 agreed, whilst 3 disagreed.

something less than a full consideration of the allegations”, nevertheless “the inquiry must be proportionate”. It argued that the Nursing and Midwifery Council’s guidance is “clearly insufficient” on this matter since it states that allegations can be accepted at “face value”.

9.213 The Professional Standards Authority opposed the proposal. It said:

We consider that it would have been helpful for the consultation document to have identified good practice and suggested its consistent adoption across the regulators. We can see little justification for divergence in the procedure to be followed at interim order hearings.

9.214 UNISON was also concerned about the impact of interim orders on registrants, particularly in cases where the main hearings are subject to significant delays. It said:

We are not aware of any initiative by any regulator that expedites prosecuting cases where a registrant is suspended over one where no order is in place. There is evidence therefore that external impetus is necessary to achieve this, and we believe that could be achieved through a set of standards applicable to all regulators.

Question 9-22: Should the statute guarantee the right of registrants to give evidence at Interim Order hearings?

9.215 An overwhelming majority agreed that the statute should guarantee the right of registrants to give evidence at interim order hearings.²⁵ For example, the Society and College of Radiographers considered that the right would “help to ensure fairness, equity and due process”. The College of Social Work said that “given the devastating effect on someone’s future career of being subject to such action they should have a right to be heard”.

9.216 The Health and Care Professions Council argued that:

Given the nature of the hearings and that the Panel’s role is not to make any findings of fact, it is rare for any person other than the registrant concerned to give oral evidence before the Panel. Guaranteeing the right of registrants to give oral evidence ensures fairness to the registrant concerned and does not place any unnecessary burden on the Panel to make an assessment of whether it would be desirable to hear specific evidence.

9.217 The Association of Regulatory and Disciplinary Lawyers argued that:

The Interim Orders Panel is often assisted in making its decision by hearing the registrant. The hearing frequently takes place before evidence can be compiled of the impact of an interim order on the

²⁵ Of the 192 submissions which were received, 47 expressed a view on this question: 43 said that the statute should guarantee this, whilst 4 disagreed.

registrant, and calling him or her is the only way of providing the Panel with the required information.

- 9.218 It also argued that, in “exceptional circumstances”, it might be important for the Panel to receive “evidence about the complaint or the complainant in order to assess if an interim order is appropriate”.
- 9.219 The Royal College of Nursing argued that the interim order procedure can be contrary to the common law and Article 6 if it fails to provide the registrant with a proper opportunity of dealing with the allegations made against them.
- 9.220 Several consultees supported the proposal, but noted that it should not be “possible to compel registrants to give evidence”.
- 9.221 The Department of Health, the Scottish Government and the Department of Health, Social Services and Public Safety for Northern Ireland all agreed that the registrant should have the opportunity of being heard in all cases.
- 9.222 The General Dental Council agreed with the proposal, provided that it is clear that “the interim orders hearing may still proceed where a registrant fails to appear or there is delay which could prejudice patient safety”. The General Optical Council felt that regulators should retain flexibility in this area and that the “default position should be that oral evidence is not taken, but that there is discretion to admit it where appropriate”.
- 9.223 The British Dental Association and the Royal College of Midwives both agreed that the statute should make provision for a case to continue in the absence of the registrant. The Local Supervising Authority Midwifery Officers Forum UK suggested that there “would have to be a ‘prior notice’ arrangement to avoid unnecessary costs being incurred”.
- 9.224 However, the General Medical Council disagreed and felt that:

It would be inappropriate to introduce a guarantee for registrants to give evidence (which would include a right for them to be cross-examined) where the function of the panel is not to make findings of fact. A guaranteed right would also mean the hearing could not proceed until the registrant was ready to give evidence which could introduce very significant delays. This would have considerable public safety risks.

- 9.225 The Nursing and Midwifery Council argued that if a right to give evidence was guaranteed, a full hearing would have to be arranged “on every review in case the registrant attended without prior notice, which would be neither proportionate nor efficient”.

Provisional Proposal 9-23: The right of appeal against an Interim Order should continue to be to the High Court in England and Wales, the Court of Session in Scotland and the High Court in Northern Ireland.

- 9.226 An overwhelming majority agreed that the right of appeal against an interim order should continue to be to the High Court in England and Wales, the Court of

Session in Scotland and the High Court in Northern Ireland.²⁶ For example, the Patients Association agreed that the proposed appeals process is acceptable “so long as it is equally applicable to complainants and registrants”.

- 9.227 However, the Administrative Appeals Chamber of the Upper Tribunal disagreed and argued that there should be a right of appeal to the First-tier Tribunal. UNISON agreed that the Unified Tribunal Service could “provide a cheaper and more accessible process”. An individual consultee (James Kellock) and the Professional Standards Authority both felt that the county court might be preferable.

Provisional Proposal 9-24: All Fitness to Practise Panels should have powers to impose the following: (1) erasure from the register; (2) suspension; (3) conditions; and (4) warnings.

- 9.228 An overwhelming majority agreed that fitness to practise panels should have powers to order erasure from the register, suspension, conditions and warnings.²⁷ For example, UNISON supported the proposal, as it has been concerned about “the inequity experienced by different healthcare professionals” in this area.
- 9.229 The Department of Health agreed with the proposal on the range of sanctions available to panels. However, it noted that erasure in health cases “needs careful consideration on a case by case basis”.
- 9.230 Some queried the role of suspensions on the basis that they have a punitive element. An individual consultee (Walter Merricks) argued that “a suspension deprives the professional of continued practice familiarity, which just means that the professional is more of a risk on returning to practice.”
- 9.231 The Nursing and Midwifery Council felt that warnings should not be available at both the investigation and sanction stages “as their effect and purpose will be confused”. The General Optical Council supported the proposal but noted that at present its panels can only issue a warning if there is no finding of impairment.
- 9.232 The Medical and Dental Defence Union of Scotland felt that the current system of a warning appearing on the registrant’s record for five years is “unfairly onerous and prejudicial” considering this is supposed to be a sanction of less significance. The Osteopathic Alliance similarly said that it would like to see a “time limit on how long an admonishment or restriction of practice should remain on a registrant’s record”.
- 9.233 Several consultees supported additional sanctions being made available, such as a power to order financial reimbursement to the patient (an individual consultee (James Kellock)), a requirement to make an apology (consultation event) and a power to end pension rights (an individual consultee (John Bradfield)). The Professional Standards Authority said “it is not clear to us why the list excludes

²⁶ Of the 192 submissions which were received, 39 expressed a view on this proposal: 36 agreed, 2 disagreed, whilst 1 held an equivocal position.

²⁷ Of the 192 submissions which were received, 48 expressed a view on this proposal: 45 agreed, whilst 3 held equivocal positions.

some of the sanctions that some of the regulators' panels currently have (eg to impose fines)".

- 9.234 RadcliffesLeBrasseur argued there should be a "specific power to take into account a period of interim suspension and, in the case of an appeal, any immediate period of suspension pending an appeal".
- 9.235 Several consultees pointed out that there should be a power to take no further action after a finding of impairment. An individual consultee (Andrew Lockley) also thought that reprimands should be available where "no order" is not enough, and conditions are too much or – more often – impracticable".

Provisional Proposal 9-25: The Government should be given a regulation-making power to introduce systems of financial penalties and cost awards.

- 9.236 Opinion was divided on the proposal that the Government should be given a regulation-making power to introduce financial penalties.²⁸ Almost half of those who responded to this proposal agreed with a regulation-making power to introduce costs awards.²⁹ The General Dental Council noted that the introduction of such systems would be "contentious and therefore arguably would be more easily accepted if the onus were on Government to introduce them".
- 9.237 The General Medical Council felt that there should be:
- A power to make costs awards against either party in circumstances where the behaviour in the conduct of the proceedings has been unreasonable. Such a sanction would have widespread benefits by ensuring that case management is effective. Experience within the tribunal sector suggests that a costs regime is a valuable and effective tool which can be used against a recalcitrant party who simply ignores case management directions, such as discovery.
- 9.238 Charles Russell LLP pointed out that the General Pharmaceutical Council uses its powers to make costs awards sensibly in situations where "the prosecutor or registrant has acted particularly unreasonably".
- 9.239 Others agreed that costs awards should be available in limited circumstances, such as where there is a clear and deliberate breach of a case management direction, or where the registrant or their representative has acted vexatiously, abusively or disruptively. The Royal College of Nursing thought that "carefully utilised costs orders would assist in achieving equality of arms". The Scottish Government supported the proposal, but was cautious that a system of financial penalties could be seen as punitive rather than rehabilitative.
- 9.240 The Health and Care Professions Council agreed with the Government being given a regulation-making power, but disagreed with the principle of financial penalties and costs awards.

²⁸ Of the 192 submissions which were received, 45 expressed a view on this proposal: 16 agreed, 22 disagreed, whilst 7 held equivocal positions.

²⁹ Of the 192 submissions which were received, 54 expressed a view on this proposal: 26 agreed, 20 disagreed, whilst 8 held equivocal positions.

9.241 The Medical Defence Union argued that costs should never be borne by the regulators. It felt that this would:

require registrants to indirectly foot the bill for costs penalties incurred by a body over whose management of cases they had no direct control, and in circumstances where they have no option but to continue to pay the annual retention fee.

9.242 It also argued that costs awards may serve as a disincentive to the registrant:

To take an example of a registrant who was offered a sanction during a consensual disposal process, but who did not believe the facts were proven and who thought that his or her case should be heard before [a Panel]. The fact that if that registrant were to be found to have impaired fitness to practise and therefore liable for costs sanctions would be a considerable disincentive to that registrant taking advantage of his or her right to a full and proper defence.

9.243 An individual consultee (Andrew Colman) also thought that “any costs jurisdiction must be reciprocal to be fair”. He noted that the costs paid by regulators would exceed those received, thus “adding to the costs of regulation to be borne by those practitioners whose fitness to practise is not in question, rather than diminishing them”.

9.244 The Osteopathic Alliance opposed the introduction of financial penalties and costs awards as “the financial, emotional and health costs to a registrant undergoing a Fitness to Practise hearing are immense already, whatever the outcome”. It thought that “the regulator itself should be subject to cost awards to a registrant” if an allegation is found to be not proven. The British Chiropractic Association also said that if costs were introduced:

it would expect to see measures to ensure that registrants are appropriately compensated in matters where the Fitness to Practice Panels have failed in their statutory duty or erred in their decision-making.

9.245 The Association of Regulatory and Disciplinary Lawyers argued that:

A costs model based on “costs follow the event” is inappropriate; firstly, the registrant is compelled to engage in this litigation and has no control over the costs, and consensual disposal (which in any event is not the same as settling) may not be an option; secondly, it is often not possible to say which side has won or lost (how should a case that results in a warning, or a case in which misconduct but not impairment is found, be treated).

9.246 Some argued that disciplinary cases differ from fitness to practise cases and it is not open to the parties to negotiate an agreed settlement and so avoid the costs of proceeding to a hearing. Thus routine costs awards against registrants would be unfair. Several consultees argued that costs awards would only achieve an increase in the cost of the procedures themselves, directly since the parties will disagree about the awards, and through satellite litigation.

9.247 The Royal College of Midwives argued that it is unfair to further punish registrants who are often suspended without pay “by applying a financial order with which they are unlikely to be able to comply”. Some disagreed with fines and costs awards on the basis that the regulatory process is concerned with public protection and not punishment.

9.248 The Society of Chiropractors and Podiatrists was one of several consultees who thought that the proposal required further consideration. It highlighted a number of potential consequences of the imposition of costs orders:

If a registrant is found to be unfit to practise and is given the relevant sanction, the award of costs against the registrant would effectively be a double sanction. Furthermore, the prospect of costs being awarded against a complainant when there is “no case to answer” could deter members of the public from making justified complaints.

On the other hand, the power to award costs could deter members of the public from making vexatious or trivial complaints.

9.249 The British Association for Counselling and Psychotherapy suggested that rather than any new powers to issue costs, non compliance should be considered as a serious misconduct issue.

9.250 The Allied Health Professions Federation argued that the power to impose financial penalties and award costs should lie with the courts, not the regulators. The Department of Health argued that the power to introduce financial penalties and costs awards should be vested in the Privy Council.

Provisional Proposal 9-26: All Fitness to Practise Panels should have powers to agree undertakings and voluntary erasure.

9.251 The vast majority agreed that fitness to practise panels should have powers to agree undertakings and voluntary erasure.³⁰ For example, the Royal College of Nursing argued that:

Currently, the inflexible menu of sanctions available at the Nursing and Midwifery Council requires even trivial cases to be run to a final hearing where there is no public interest in that hearing, and the distress caused to the registrants and the drain on resources to the Nursing and Midwifery Council and registrants’ representatives is considerable. Similarly, when the registrant just wants to retire with dignity and the issue is health or competency in a long-serving nurse who has begun to show signs of failing to keep up to date, the current arrangements are inhumane. Providing a mechanism to take such cases out of the system will free up the Nursing and Midwifery Council’s resources to focus upon the cases that should be heard in public. We also think that involving the registrant in finding a suitable resolution in less serious cases will require the registrant to take responsibility for their actions that will aid their insight and reduce the

³⁰ Of the 192 submissions which were received, 44 expressed a view on this proposal: 40 agreed, whilst 4 held equivocal positions.

sense of bitterness about the sanction that we frequently observe at the end of a case.

9.252 The Health and Care Professions Council supported the proposal and said that:

Such powers provide regulators with flexibility in their adjudicative approach. In providing such flexibility, however, care has to be taken to ensure justice, fairness, openness and transparency whilst also ensuring public protection.

9.253 Consultees' concerns about the use of consensual disposals were also reflected in their responses to provisional proposal 8-16 (see Part 8 of this document) in relation to the range of actions available to the regulators at the investigation stage. In addition, Action Against Medical Accidents stated that:

Even where a health professional has already left the register, regulators should have a power (and a duty) to investigate and record findings to mitigate the risk of that health professional re-joining the register at a later stage without the concerns having been addressed, or the health professional registering in a different country without the concerns coming to light.

9.254 The General Dental Council stated that regulators should have the power to make rules to introduce voluntary erasure should they wish to do so.

9.255 The Professional Standards Authority argued that any system of consensual disposals should provide:

a guaranteed degree of transparency in relation to the outcome, including publication of a clear statement which specifies the nature of the misconduct (or other basis for the impairment finding) that has been committed and which sets out the consequences of any failure by the registrant to comply with any undertaking or, in the case of voluntary erasure, any attempt to reregister in future.

9.256 The National Clinical Assessment Service acknowledged the need to deal with fitness to practise cases quickly and in a non-punitive way, but felt that:

there is a danger when not holding a (public) hearing that the public perception will be one of healthcare professionals being dealt with by other healthcare professionals behind closed doors.

9.257 In relation to voluntary erasure, the Department of Health argued that the regulators should be required to maintain a list of persons whose applications for voluntary erasure were granted before the conclusion of an investigation. It also suggested that voluntary erasure could be limited to cases where the practitioner and regulator produce "a statement of agreed facts, which is published, and so avoids disputes in the future as to the factual basis of a case". The Department felt this would mean that "where someone wishes to be restored to the register that the fitness to practise issue can also be revived if necessary".

9.258 The Scottish Government also supported the proposal on consensual disposals but only on the basis that voluntary erasure is:

carefully considered in particular in relation to any individuals that may have been harmed as a result of the action of the registrants and the need for them to be protected and be afforded some form of redress.

- 9.259 It also argued that the regulators should be required to maintain a list of those practitioners who have agreed to voluntary erasure and “to share this information with other European Economic Area competent authorities”.

Provisional Proposal 9-27: The regulators should have powers to introduce immediate orders (or use Interim Orders for this purpose).

- 9.260 An overwhelming majority agreed that the regulators should have powers to introduce immediate orders (or use interim orders for this purpose).³¹
- 9.261 The Health and Care Professions Council argued that interim orders should be used to cover the appeal period before a fitness to practise sanction takes effect. It did not see a need for the introduction of a separate immediate order power “which could confuse the public and registrants”. In addition, the Council suggested that any interim order made to cover an appeal period “should be made by way of a separate decision (albeit within the same hearing), to ensure that the registrant has the right to make submissions”.
- 9.262 In contrast, the Nursing and Midwifery Council supported the use of immediate orders and felt that the use of interim orders in this instance was inappropriate. The Royal College of Midwives also felt that immediate orders should be used on the basis that “it is not proposed that they be reviewed in a set time”.
- 9.263 However, the Professional Forum of the Pharmaceutical Society of Northern Ireland argued that the use of immediate orders should be limited to “the most extreme cases” and “with the caveat that such orders could be appealed immediately to the High Court”.
- 9.264 The General Optical Council argued that the power to issue immediate orders should be available following review hearings. The Optical Confederation thought that “immediate orders should be provided for in the new statute and these should be able to be sought by either party”.
- 9.265 The Department of Health felt that interim orders could be applied by fitness to practise panels without the need to convene a separate Interim Orders Panel. It argued that the order-making power in relation to new sanctions should be vested in the Privy Council.
- 9.266 The Scottish Government also commented that some regulators have the power to impose an interim order without the need to convene a separate Interim Orders Panel and “this could be extended to all the regulators and would afford a more speedy form of public protection”.

³¹ Of the 192 submissions which were received, 42 expressed a view on this proposal: 38 agreed, whilst 4 disagreed.

Provisional Proposal 9-28: The test for imposing any of the sanctions listed in provisional proposal 9-24 and consensual disposals in 9-26 should be to protect, promote and maintain the health, safety and well-being of the public (and maintain confidence in the profession).

- 9.267 A significant majority agreed with our proposed test for imposing sanctions and consensual disposals.³² For example, a consultee at a consultation event thought the proposal was “necessary and is a focus which is currently missing at some regulators”.
- 9.268 A number of consultees pointed out that the use of the word “and” implies that a sanction could only be imposed on the ground of public confidence where there was also an issue of risk or potential risk. It was suggested that the test should be based on whether the registrant poses a risk to the public “or” that confidence in the profession has been or will be undermined.
- 9.269 The Health and Care Professions Council agreed with the proposal and also argued that “public faith in the regulatory process” is crucial to the imposition of sanctions and operation of consensual disposals. The General Dental Council also raised concerns about the use of the term “well-being” which it felt was “inappropriate” (see discussion on the main duty in Part 3).
- 9.270 The Medical Protection Society agreed with this proposal, but also added that:
- (1) the sanction must be proportionate – the Panel must balance the interests of the public against those of the registrant;
 - (2) the sanction must not be punitive – it must aim to protect patients and the wider public interest; and
 - (3) the Panel must take into account “mitigation, remediation, testimonials, insight and apology” when deciding sanctions.
- 9.271 The Professional Standards Authority disagreed with the proposal and argued that the statute should retain the current three stage test of:
- (1) public protection;
 - (2) declaring and upholding professional standards; and
 - (3) maintaining confidence in the profession.
- 9.272 It was also argued that the test should be expanded to include the need to maintain confidence in the regulatory system.
- 9.273 UNISON also disagreed and argued that the test should be public protection rather than maintaining confidence in the profession.

³² Of the 192 submissions which were received, 45 expressed a view on this proposal: 40 agreed, 4 disagreed, whilst 1 held an equivocal position.

Provisional Proposal 9-29: The regulators should be given broad powers to make rules in relation to the sanctions listed in provisional proposal 9-24 and consensual disposals in provisional proposal 9-26.

9.274 The vast majority agreed with the proposal.³³ For example, the British Pharmaceutical Students' Association acknowledged that the General Pharmaceutical Council's rules may be "proportionate for pharmacy but may not be proportionate for other healthcare professions".

9.275 The Medical Defence Union agreed "with the proviso that the adjudicatory function is separated from the regulator", as has been implemented at the General Medical Council. It felt that:

We have long-standing concerns about advice/guidance circulated routinely to panellists by regulators which may amount to advice given to adjudicating panellists by the prosecuting arm. In order to provide a safeguard against this, we believe there should be a further stipulation that advice/guidance to panellists should be issued by the regulator/separate body responsible for the Fitness to Practise Panel and not the prosecuting arm of the regulator.

The duty upon the adjudicatory body should be no greater than to consider indicative sanctions guidance provided by the regulator as the body responsible for setting standards; but the adjudicatory body must be free to determine sanctions as it sees fit.

9.276 The Health and Care Professions Council argued that the statute should provide for "mandatory reviews of suspension and conditions of practice orders and the length of time such orders should be imposed for" which "should not be left to the discretion of individual regulators".

9.277 However, the Professional Standards Authority disagreed, and stated:

We believe that it would be preferable for a degree of consistency to be achieved by imposing a common sanctions framework across the regulators. This is particularly important for the maintenance of public confidence in the regulators generally, given the concerns that arise about different sanctions being imposed in closely connected cases.

9.278 The Royal College of Nursing called for "a mechanism for oversight so that there is consistency". UNISON suggested that "consistency and economies of scale could be achieved if a basic rules standard is applied across all regulators".

9.279 The Department of Health called for "constraints to ensure consistency of approach in relation to issues touching on the fairness of applying particular sanctions in particular cases", for example health cases. The Scottish Government expressed caution in relation to broad rule-making powers. It urged that "a consistent approach is applied, particularly in relation to issues which cover certain sanctions in relation to health cases".

³³ Of the 192 submissions which were received, 42 expressed a view on this proposal: 40 agreed, whilst 2 disagreed.

Provisional Proposal 9-30: The Government should be given a regulation-making power to add new sanctions and consensual disposals to those listed in provisional proposals 9-24 and 9-26, and to remove any sanctions and consensual disposals.

9.280 A large majority agreed that the Government should be given a regulation-making power to amend the statute to add or remove sanctions and consensual disposals.³⁴ For example, the Patients Association said that:

There does indeed need to be a process through which new sanctions may be added to the list of possible sanctions available to the regulators. The Government, with the appropriate oversight of Parliament, is the right body to undertake this function.

9.281 The General Medical Council said:

The nature of risk is dynamic and changes over time as the context in which professionals work changes and evolves. Society's appetite for risk also evolves. It will be important that there is a mechanism to make changes over time.

9.282 A small number of consultees expressed concern about this proposal. The main arguments are set out in Part 8 in the discussion concerning the powers of regulators to dispose of cases during the investigation stage.

9.283 RadcliffesLeBrasseur did not think it was "clear why it should be thought that the powers given to erase, suspend or impose conditions are not wide enough". The Medical Protection Society questioned "whether in practice it would ever be necessary for the Government to invoke this power".

9.284 Some consultees emphasised that the competence of the devolved administrations must be adequately respected if this proposal is adopted. For example, the Scottish Government noted that its support for the proposal was "on the proviso that the competence of the Scottish Parliament is respected where applicable".

Question 9-31: Does the language used in the proposed list of sanctions and consensual disposals contained in provisional proposals 9-24 and 9-26 convey accurately their purpose?

9.285 A majority agreed that the language did convey the sanctions' purpose.³⁵ For example, the Department of Health and Scottish Government considered that the language used in the consultation paper was appropriate.

9.286 Some felt that the term "warning" was not appropriate and preferred "caution". An individual consultee (Lucy Reid) felt that "warnings" can be misunderstood and seen by the public as "merely a slap on the wrist". The Health and Care

³⁴ Of the 192 submissions which were received, 40 submissions expressed a view on this proposal: 34 agreed, 3 disagreed, whilst 3 held equivocal positions.

³⁵ Of the 192 submissions which were received, 43 expressed a view on this question: 27 agreed with the language, 2 disagreed, whilst 14 held equivocal positions.

Professions Council felt that a “caution” is understood as an “official rebuke” but it was not necessarily expected to appear on a registrant’s record, whereas a “warning” is viewed as “a more familiar term, carrying more weight and implying a formal procedure”.

- 9.287 The General Dental Council felt that “undertakings” suggests that “a registrant has simply promised to behave properly; it does not in itself imply that there are conditions or monitoring in place” and suggested the terms “conditions” or “agreed conditions” instead. The General Social Care Council felt that “undertaking” would be viewed as “obscure by members of the public”. It also felt that the current language “does not fully capture the nature of the arrangement” whereby “the registrant has agreed to amend his or her practice or behaviour as a condition of being allowed to hold a licence to practice”.
- 9.288 Several consultees argued that “erasure” is not clear, and the General Medical Council said the term was “overly technical and legalistic”. Alternative suggestions included “striking off”, “struck off”, and “removal from the register”. For example, the Patients Association argued that “striking off” is “clear, in widespread use and understandable”. The General Pharmaceutical Council, however, reported that it avoids using the term “striking off” or “struck off” which in its view is “emotive, unhelpful and old-fashioned”.
- 9.289 The General Medical Council suggested that the term for “voluntary erasure” must be distinct from the term used when a Fitness to Practise Panel erases a doctor from the register or “when, under the consensual disposal provisions, the regulator demands and the registrant agrees that their name be removed from the register”.
- 9.290 The Pharmaceutical Society of Northern Ireland was also concerned about the language used in respect of consensual disposals. It said:
- The language inaccurately conveys the purpose of these powers. There is considerable scope for confusion around the terms voluntary erasure and consensual disposal and the language does not accurately communicate or reflect the outcomes. In plain English, the terms do not identify to the public that the registrant has been subject to due process and has been judged at the same threshold as a final fitness to practise panel.
- 9.291 The Professional Standards Authority argued that the priority is to communicate clearly to the public and employers “the extent/lack of any difference in the impact of a sanction depending on whether it is consensual or has been imposed at the end of the hearing process”. The British Association for Counselling and Psychotherapy said that the “perception of protection for the public is crucial”, and so the “language needs to be emphatic in this instance”.
- 9.292 Many consultees combined their answer to this question with their response on consultation question 8-19 regarding the nomenclature used to describe the disposals available at the investigation stage (see Part 8 of this document).

Provisional Proposal 9-32: The statute should require all the regulators to establish a system of review hearings for conditions of practise and suspension orders. In addition, the regulators should have powers but would not be required to establish review hearings for warnings and undertakings.

9.293 An overwhelming majority agreed that the statute should require all the regulators to establish a system of review hearings for conditions of practise and suspension orders.³⁶ A significant majority agreed that the regulators should have powers to establish review hearings for warnings and undertakings.³⁷ For example, the Patients Association supported the proposal, “particularly ... that the process should be specifically defined in the statute”.

9.294 However, several consultees felt that there should be a duty to establish a system of review hearings for undertakings. For example, the Professional Standards Authority argued that undertakings are in effect conditions that have been imposed with a registrant’s consent and, therefore, should not be treated differently in terms of review requirements.

9.295 Some disagreed with a system of reviews for warnings. For example the General Medical Council stated that:

There would be no expectation that a registrant carry out remedial action following a warning and the only matter that might be considered on review would be whether the behaviour had been repeated in the interim period. In that case, a regulator could in any event take action in the event of repetition and a review process would be unnecessary and overly burdensome.

9.296 Similarly, the Medical Defence Union stated that:

These are meant to be a way of admonishing the registrant that does not require any action and there is no requirement upon a registrant to demonstrate anything in response to a warning. Its purpose is to lie on the file in an advisory capacity, for a specified period. We cannot see, therefore, how a review of a warning would work in practice and would strongly resist any suggestion that warnings should be in any way extended after the set period has elapsed.

9.297 However, RadcliffesLeBrasseur disagreed and said that:

A warning can have serious consequences. At present it appears that insurance companies will remove a medical registrant from their approved list of providers if a warning is given. There should be a requirement to offer a registrant a hearing if he does not wish to be warned.

³⁶ Of the 192 submissions which were received, 44 expressed a view on this proposal: 41 agreed, 2 disagreed, whilst 1 held an equivocal position.

³⁷ Of the 192 submissions which were received, 41 expressed a view on this proposal: 35 agreed, whilst 6 disagreed.

9.298 The General Dental Council thought that the “regulators should have rule-making powers in this respect”,

9.299 The Health and Care Professions Council disagreed generally with the proposal and argued that the statute should specify the requirements and systems for review hearings in order to ensure “transparency and consistency”. The Professional Standards Authority also argued that:

There is little value to be obtained from achieving consistency in the name of the sanctions that can be imposed if, in reality, the same named sanction may have a very different impact, eg if a “warning” will be reviewed by one regulator, but not by another.

9.300 The Scottish Government supported the proposed duty to establish review hearings, but also noted that:

This is an area where there is already a degree of commonality between the regulators and would suggest that this could be an area where joint working may be appropriate.

9.301 It also argued that the Professional Standards Authority should monitor and scrutinise the review procedures adopted.

9.302 The Royal College of Obstetricians and Gynaecologists also thought that “all regulators should work the same way” in respect of undertakings and warnings.

Provisional Proposal 9-33: The regulators should have broad rule-making powers to establish the procedures for review hearings.

9.303 The vast majority agreed that the regulators should have broad rule-making powers to establish the procedures for review hearings.³⁸ For example, the Professional Forum of the Pharmaceutical Society of Northern Ireland supported the proposal, “with the appropriate safeguards being created by the process of full stakeholder consultation”.

9.304 However, many argued that full hearings are not always necessary. For example, the Nursing and Midwifery Council suggested that some reviews could be “conducted, by consent, at meetings without the need to convene a full hearing”. The Royal College of Nursing felt that regulators should only hold review hearings if there is a dispute regarding the continuation of the existing sanction.

9.305 The General Medical Council felt that the statute should not “require reviews to be carried out by the Registrar where the proposals are uncontested”. It felt that:

This would avoid unnecessary hearings and prevent adjudication resources being diverted from interim orders and fitness to practise hearings by large numbers of review hearings.

³⁸ Of the 192 submissions which were received, 38 expressed a view on this proposal: 36 agreed, whilst 2 disagreed.

9.306 It also argued that registrants should have a right of appeal against review decisions.

9.307 The Medical Defence Union argued that a review of undertakings by a Fitness to Practise Panel would be “disproportionate and unnecessary”, since:

The purpose of undertakings is that they are a faster way of achieving the same protections as conditions, without a fitness to practise hearing. It would defeat their purpose for them to be reviewed by a Fitness to Practise Panel.

9.308 The Administrative Justice and Tribunals Council argued that the procedures for review hearings should be “harmonised across the board”. Similarly, the Professional Standards Authority felt there was “little justification for significant divergence in the appropriate procedure”.

Question 9-34: Should the regulators be given an express power to quash or review the decision of a Fitness to Practise Panel where the regulator and the relevant parties agree that the decision was unlawful? If so, should complainants and other interested parties be able to prevent or contribute to any decision to use this power?

9.309 A small majority felt that the regulators should be given an express power to quash or review such decisions.³⁹ A slim majority felt that complainants and other interested parties should have a role.⁴⁰

9.310 The Nursing and Midwifery Council supported the introduction of such a power on the basis that:

At present, even if we actively encourage the Professional Standards Authority to pursue an appeal against a panel decision that we consider to be wrong, and then consent to the decision being quashed, we may still find ourselves liable to pay a significant sum in costs. This proposal would avoid such a situation.

9.311 The Administrative Appeals Chamber of the Upper Tribunal noted that section 9 of the Tribunals, Courts and Enforcement Act 2007 enables the First-tier Tribunal to review its decisions on the ground of error of law.

9.312 An individual consultee (Andrew Lockley) suggested that only part of a panel’s decision might be unlawful and therefore “it should also be possible for regulators to quash only that part of the decision, rather than the parties have to go to appeal”.

9.313 The Department of Health, Social Services and Public Safety for Northern Ireland generally supported the idea that a regulator should be able to quickly remedy an error. It sought clarity over whether the original Panel which made the decision

³⁹ Of the 192 submissions which were received, 53 expressed a view on this question: 30 said the regulators should have such a power, 16 disagreed, whilst 7 held equivocal positions.

⁴⁰ Of the 192 submissions which were received, 14 expressed a view on the question: 8 agreed with the question, whilst 6 disagreed.

would need to recognise its mistake and take action itself, or whether a new panel would “scrutinise the legality or otherwise of a decision”.

9.314 The Medical Defence Union felt that the power to quash or review decisions should only apply where the regulator and the registrant agree the decision was unlawful. The complainant and any other interested parties should have “no part in such decisions” since “they may have an interest in the outcome, but have no rights in the procedure as they are not a party to it”. However, the General Osteopathic Council believed that the “consent of the regulator, registrant and complainant” would be required before any exercise of the power.

9.315 Similarly the Association of Regulatory and Disciplinary Lawyers stated:

We do not think that the complainant should have any role in this decision; he or she is not a party to the proceedings, and if the regulator is in error in agreeing to the quashing of a finding on the basis of unlawfulness, the Council for Healthcare Regulatory Excellence can refer the matter to the High Court for resolution.

9.316 The Professional Standards Authority was generally supportive but also stated:

We are, however, unclear as to the review mechanism that is proposed - would the matter be put before another panel, or would the decision-maker be the Registrar or other individual? We would have concerns about public confidence in the process if the review were to be conducted by someone other than a panel. If the basis for the review is unlawfulness, it is difficult to see the relevance of any contribution that the complainant/other interested party could make.

9.317 However, many consultees disagreed with the introduction of a power to reconsider decisions. For example, the General Medical Council argued that such a power would:

introduce significant bureaucracy which will divert regulatory resources away from the core functions of investigation and adjudication. In addition, we believe that the overturning of a decision of a Fitness to Practise Panel should, as now, be overseen by the courts.

9.318 The Scottish Government felt “uncomfortable” with such powers being given to regulators. It said:

It is our view that without the necessary checks and balances and involvement of external/higher authorities, it is possible to envisage the situation whereby this mechanism could become more frequently used than initially intended (and, in some cases, misused), has the potential to become a regular feature of the process and could lead to undermining of the fitness to practise process.

9.319 RadcliffesLeBrasseur argued such a power would:

undermine confidence in the independence and integrity of the fitness to practise process if the prosecution and defence (with or without others) can set aside their decision.

- 9.320 The Royal College of Surgeons of Edinburgh was concerned that such a procedure might “create a legal loophole” whereby:

legal technicalities may cause a case to be dropped (as it is deemed “un-lawful”) despite there being sufficient evidence of the individual concerned not being fit to practise.

- 9.321 The Department of Health considered that, unless “the scope for reconsideration is tightly constrained”, this power could become a mechanism to challenge and overturn legitimate decisions “without recourse to a formal appeal”.

- 9.322 The Patients Association stated that:

Where the complainant or registrant alone is raising the problems, there should be an effective appeal procedure in place which operates internally as well as the option to seek judicial review.

- 9.323 An individual consultee (Walter Merricks) felt it would be “unduly complicated to provide for an informal quashing mechanism”. He also argued that:

Where both parties and other interested parties all agree that a decision should be quashed then obtaining orders to that effect from the Administrative Court is not onerous. At least in that process there is the possibility of external oversight.

- 9.324 The Administrative Justice and Tribunals Council argued that fitness to practise panels should be able to review their own decisions. Similarly the General Chiropractic Council felt that panels “should be given a slip rule of power, ie where there is an obvious mistake, to correct that mistake within [the] 72 hours”.

- 9.325 UNISON also argued that “other interested parties”, such as complainants, should not have any role since “these are not complaints procedures” and “are funded by registrants and should not stray beyond the issue of a registrant’s fitness to practise”.

- 9.326 However, several consultees were in favour of other interested parties having some limited involvement in any review. Coventry and Warwickshire Partnership Trust said:

Best practice would suggest that the complainant and other interested parties should be made aware of the decision, and why the decision has been taken, but this does not necessarily mean that they have a right to prevent the decision being taken, however it may be necessary to seek their opinion in order to allow reviews to happen in a timely and fair manner and prevent subsequent appeals.

- 9.327 Rescare thought that “complainants and other interested parties should have some legal recourse, in limited situations”. The British Dental Association saw “no

reason why there should be any trammelling of the power by any interested party, but they might be able to contribute to the review”.

Provisional Proposal 9-35: All professionals should continue to have a right of appeal against the decision of a Fitness to Practise Panel to the High Court in England and Wales, the Court of Session in Scotland and the High Court in Northern Ireland.

9.328 The vast majority agreed with this proposal.⁴¹ For example, the Professional Forum of the Pharmaceutical Society of Northern Ireland said it “believes [the right of appeal] is a fundamental protection for all registrants and continues to fully support this practice”.

9.329 However, several consultees pointed out that the costs involved in pursuing an appeal to the higher courts make this more of a theoretical right than a real one. UNISON argued that this is a particular problem for those registrants who are not members of a professional association or trade union. It was suggested that the regulator should be able to establish internal appeals procedures.

9.330 In addition, the General Social Care Council considered that:

The range of professions which are now subject to regulation and the different levels of income received by these professions are vastly different and this should certainly be a consideration when determining whether the High Court is the most appropriate place to hear appeals against the decision of professional regulators. An impact assessment should be conducted on this issue – taking into account whether the cost of a High Court appeal may be more prohibitive for certain regulated groups – before this proposal is finalised in primary legislation.

9.331 The Administrative Appeals Chamber of the Upper Tribunal argued that the Upper Tribunal (Administrative Appeals Chamber) would be “a more appropriate destination for appeals than the High Court and the Court of Session”. This was supported by the Administrative Justice and Tribunals Council. An individual consultee (James Kellock) felt that appeals should be transferred to the “county court in England, and the equivalents in Scotland and Northern Ireland”.

9.332 The General Chiropractic Council pointed out that it has powers to establish an internal appeals committee if a registrant is found unfit to practise due to ill health and thereafter, a further appeal to the High Court is available. It therefore considered:

That both in respect of appeals against a decision on health and erasure, either permanently or temporary suspension, an internal appeal process should be available as in other professions. To avoid frivolous appeals, the registrant should be required to pay the costs of an appeal in advance which of course would be returned in the event of a successful appeal.

⁴¹ Of the 192 submissions which were received, 47 expressed a view on this proposal: 44 agreed, 2 disagreed, whilst 1 held an equivocal position.

9.333 The Professional Standards Authority agreed that “the advantages of such an approach would principally relate to efficiency and cost, given the length of time it takes the courts to hear appeals”.