PRIMARY HEALTH LISTS **Case No PHL 15352**

IN THE MATTER OF AN APPLICATION FOR A NATIONAL DISQUALIFICATION

NHS PERFORMERS LIST REGULATIONS 2004

TRIBUNAL PROCEDURE (FIRST TIER TRIBUNAL) (HESC) RULES 2008

BETWEEN:

WESTERN CHESHIRE PRIMARY CARE TRUST

Applicant

and

DR JOHN STEPHEN HOOD

Respondent

Before

Judge J Burrow

Dr G K Sharma

Mrs MJ Frankel

Sitting at Pocock Street London SE1 0BW on 16 August 2011.

1. The application

1.1 This is an application by West Cheshire PCT (the PCT) for a National Disqualification to be imposed on Dr John Hood pursuant to Regulation 18A (3) of the National Health Service (Performers Lists) Regulations 2004 (as amended) (the 2004 Regulations).

1.2 The Application was made on 13 January 2011. Dr Hood initially indicated he wished to contest the application, but on 7 July 2011 withdrew his opposition, without having submitted a response to the application. On 8.7.11 a direction was made that the case be heard on the papers. The PCT compiled a bundle for the hearing which included the case

summary, witness statement s and appendices from Alison Swanton, Amanda Lonsdale, Lucy Reid, Diane Hyde, Diane Verkade and Julie Critchley.

1.3 Also included in the bundle were 4 psychiatric reports from Dr McCarthy and Professor Healy who were commissioned by Dr Hood and Dr Holloway and Dr Sillince who were requested by the GMC to assess Dr Hood's Fitness to Practice. Dr Hood submitted a basis of plea and the judges sentencing remarks. In all there were 489 pages of evidence.

2. Legal framework

2.1 Regulations 18A (3) and (4) of the 2004 Regulations give a PCT the power to apply to the Primary Health Lists (PHL) within three months of the date of the removal of the practitioner from the Performers List, for a national disqualification to be imposed on the practitioner.

2.2 Regulation 18A(5) provides that if the PHL tribunal imposes a national disqualification on a person, no PCT may included him in any performers list from which he has been so disqualified and if he is included in any such list from which he has been so disqualified, a PCT shall remove him from that list forthwith.

2.3 Regulations 18A (6) and (7) provide that the PHL tribunal may at the request of a person upon whom it has imposed a national disqualification, review that disqualification and confirm or revoke that disqualification.

2.4 Regulation18A (8) provides that subject to regulation 19, a request referred to in Regulation 18A (6) may not be made before the end of the period of

(a) Two years beginning with the date on which the national disqualification was imposed or
(b) One year beginning with the date of the PHL's decision on the last such review.

2.5 Regulation 19(a) provides that the period for review shall be five years instead of two, if on making a decision to impose national disqualification, the PHL tribunal states that it is of the opinion that the criminal or professional conduct of the practitioner is such that there is no realistic prospect of a further review being successful if held within the period specified in Regulation 18A(8).

2.6 The Department of Health's guidance for PCTs entitled "Primary Medical Performers Lists - Delivering Quality in Primary Care" sets out some of the issues to be taken into account in considering an application for a National Disqualification. We had regard to the statement in the document that we "should recognise the benefits of a national disqualification both for protecting the interests of the patients and for saving NHS resources". We further noted we should have regard to the seriousness of the facts which gave rise to the original removal and to whether the reasons for the removal were "essentially local".

2.7 We further had regard to the proportionality of making an order for national disqualification, taking into account the seriousness of the reasons for removal, including any risks to patients, the explanations and any mitigation submitted by the practitioner, the extent to which the allegations have or can be remedied and any insight shown by the practitioner. We also took into account the interests of the practitioner in being able to pursue his profession.

2.8 The burden of proving an issue lies on the party asserting it to the civil standard. Whether an order for national disqualification should be issued is a matter of judgement for the tribunal, taking into account all the relevant issues.

3. Evidence

3.1 Dr Hood qualified as a medical practitioner in 1978. In the 1990s he moved to the Northwest and held a number of posts working as a police surgeon and undertaking out of hours work. In 2004 he contracted with the PCT to provide medical services to Diamond and Ruby Wards at Ellesmere Port Hospital (EPH), a cottage hospital providing intermediate care and rehabilitation services. In 2007 he started a business partnership with Dr A to share the responsibilities at EPH and entered in an Alternative Provider Medical Services (APMS) contract jointly. Later in 2007 the two began a personal relationship which ended in about April 2010

3.2 On 28th August 2010 Dr Hood went to Dr A's house and used a key which he still possessed to gain entry. Dr A's children were in the house, Child B being a 14 year old girl and Child C being a 16 year old girl. He was carrying an axe and a can of petrol. He noticed the children on entry and issued a threat against Dr A, saying, "She's a bitch. I need to sort it out. She's taking advantage. I've got unfinished business." He proceeded to Dr A's bedroom and closed the door after he had entered.

3.3 The children became hysterical and were screaming. Later they said they believed Dr Hood intended to kill their mother. In the bedroom Dr Hood waved the axe, grabbed at Dr A and hacked at furniture. He made further threats against Dr A. He removed the lid from the can of petrol and either deliberately poured, or allowed to spill onto the floor, some of the petrol. Dr A later said that she believed he intended to kill her. She said he looked irrational and out of control.

3.4 Dr A managed to exit the bedroom and ran with the girls down the stairs and out of the house. Dr Hood followed, spilling more petrol on the stairs and in the hall and breaking the front door window with the axe. He chased the three, who were in their night clothes and underwear, down the driveway and onto the road where he threw the axe at Dr A, missing her but coming close enough so that she could pick the axe up and throw it away.

3.5 Dr A and the girls ran to a neighbour's house where they contacted the police who arrested Dr Hood at a friend's house the following day. Dr Hood was remanded into custody until 16th October 2010. On the 15th November 2010 he pleaded guilty to affray on the basis that he intended to frighten Dr A, not harm her. Dr A later said she did not mean some of the

things she had said in her statement, but she did not say what these were and in any event much of the account was corroborated by the evidence of the children.

3.6 On 17th December 2010 he was sentenced to eight months imprisonment, suspended for 24 months and made subject to supervision for a period of six months. He was also made subject to a restraining order prohibiting him from coming within 50 yards of Dr A's address or contacting the children without Dr A's permission for five years. He was also required to perform 160 hours of unpaid work.

3.7 On 12th January 2011 the applicant was removed from the PCT's medical performers list on the mandatory ground, under regulation 10(1)(b) of the 2004 Regulations, that a performer has been convicted of a criminal offence and a term of imprisonment of more than six months has been imposed. A suspended term of imprisonment of more than 6 months would fall within this definition.

3.8 On 13th January 2011 the PCT applied for a national disqualification under regulation 18(A) of the 2004 regulations against Dr Hood on the grounds of his conviction and eight months suspended sentence of imprisonment.

3.9 The PCT say that a national disqualification is appropriate by reason of the seriousness of the circumstances of the affray, the criminal conviction, and the sentence imposed in relation to it, being not only an eight month suspended prison sentence, but a very lengthy restraining order intended to protect Dr A and her family. Furthermore Dr Hood has been removed from the performers list on a mandatory ground.

3.10 The PCT argue that a suspended prison sentence is not universally acknowledged by PCTs as constituting a mandatory ground, creating uncertainty in Dr Hood's ability to secure membership on a performers list. This is in contrast to the certainty of a national disqualification. Further it is suggested that Dr Hood may apply for posts where inclusion on a performers list is not necessary and it is argued that a reasoned decision letter will give the prospective employer necessary information about Dr Hood.

Dr Hood's explanations

3.11 Dr Hood has not submitted a formal response to the PCTs application for a national disqualification but his explanations for his behaviour are known through the four psychiatric reports. He mentioned a number of factors which he said put him under considerable stress at the time of the incident.

3.12 Work stresses and patient safety

a. In the period prior to the incident Dr Hood claimed that he was under intense pressure from his work load. He stated that his contract to provide medical services to EPH had intensified over time because of a change in discharge criteria from the local acute hospital to EPH. He stated that this change meant patients were generally more unwell and required more substantial medical services from himself and Dr A. The PCT accept that there had been some minor changes in discharge criteria about 18 months before the incident but

that this had had little effect on the work load of Dr Hood. Patients continued to be discharged to EPH as being suitable for primary care. It was predominately their nursing needs which were more complex. The PCT noted there was no appreciable rise in readmission rates to the local acute hospital from EPH which might have been expected had patients been significantly more unwell. The PCT noted that Dr Hood had never made any complaint about any increase in work load or his ability to treat patients, or that patients were at risk because of the changes. The APMS contract made provision for use of locums which were, in fact, used from time to time. Further the PCT noted that while Dr Hood invoiced for100% of the EPH work in April and May 2010, he only invoiced for 50% in June and July 2010 and just 3 % in August. It appears the business relationship between Dr Hood and Dr A deteriorated once their personal relationship ended in April 2010 and in April and May Dr A played little part in providing services at EPH, returning in June 2010 to undertake more of the services herself. It appears therefore that Dr Hood's commitments under the APMS contract significantly reduced in the period immediately before the incident on 28 August 2010. Furthermore the PCT suggest that Dr Hood's duties at EPH involved just a few hours attendance a day and were far from onerous. Funding was generous for this work and taken with monthly invoices for out of hours calls to the hospital were substantial and his OOH GP work was in addition to this. On the day of the incident he was upset because Dr A had asked him to change shifts.

b. It seems there were some problems in providing e-discharge records with patients admitted to EPH, but the PCT do not accept that this created much, if any, additional work for Dr Hood.

c. As well as providing medical services to EPH on a full time basis, Dr Hood also undertook local Out of Hours Work. This would entail being on call for periods of time during the week. On some 20 occasions during April and May 2010 it was noted his duty hours under OOH overlapped with his responsibilities to EPH, which may have meant patients were theoretically at risk of a delay in responding to any emergency. The PCT accept that the two sets of responsibilities had meant that Dr Hood was working an excessive number of hours. They point out that if this excessive workload had caused undue tiredness in Dr Hood, it may have meant that patients were at least theoretically at risk. Had the PCT appreciated Dr Hood had chosen to undertake these dual responsibilities they would have taken steps to prevent it. They make the point that it was Dr Hood's choice to undertake dual responsibilities, almost certainly in an effort to relieve his financial difficulties, and if patients were placed at risk it was because of the actions taken by Dr Hood and not through the PCT requiring him to work unreasonable hours. The PCT also refer to Dr Hood's personal responsibilities under Section 6 of the GMC Good Medical Practice to take action personally if patient safety is compromised.

d. On 26 August 2010 just two days before the incident, the PCT met with Dr Hood to discuss the circumstances in which the APMS contract had been signed in November 2008. The contract forbids any signatory to be subject to bankruptcy or to an Interim Bankruptcy Order. It appears that at the time Dr Hood signed the agreement on 13th November 2008 he was subject to an IBO. The PCT informed him that they would in all probability regard the contract as void. The PCT accept that this would have caused stress to Dr Hood, but again they point to the fact that the situation was of his own making.

Depressive Illness

3.13 It appears that during the latter part of 2009 Dr Hood attended his GP reporting depressive symptoms. This appears to have been initiated by him being given notice from a job as a police surgeon. The GP prescribed fluoxetine (Prozac) initially at 20mg, later increased to 40mg and subsequently, when his son was unwell, to 60mg a day. Even 60mg a day is a therapeutic dose and not excessive. After his son improved, the dosage was reduced until it was back to 20mg in June 2010. Dr Hood accepted that he was not suffering from a depressive illness at the time of the incident.

Son's Illness

3.14 Dr Hood's adult son became seriously ill with acute myocarditis towards the end of 2009. He spent six months in the coronary care unit. It seems for a period Dr Hood took over the care of his son. By April 2010 it appears the son's health had improved and by June the difficulties were largely ended.

Relationship with Dr A

3.15 It seems Dr Hood's relationship with Dr A began to deteriorate in the latter half of 2009 and it ended in April 2010. It appears his relationship difficulties may have been a contributing factor to his depressive illness and constituted a significant stressor which continued until the time of the incident.

Financial Difficulties

3.16 It appears Dr Hood had been trading on the stock market for some time. Initially successful, his trading later caused significant loses, including a loss of £50-60,000 in one day. It was these losses which doubtless contributed to his bankruptcy. The PCT suggest this is one aspect of his personality which can, at times, lead him into acts of extreme recklessness. Furthermore, they point to the fact that his financial difficulties remain and are likely to continue to exert stresses in his life at the present day.

Psychiatric Reports

3.17 Dr McCarthy, a consultant psychiatrist, was instructed by Dr Hood's solicitors to compile a psychiatric report dated 4th October 2010. After reviewing the stresses mentioned above as well as his family, medical and psychiatric history, and his personality, Dr

McCarthy considered why the index offence had occurred. She concluded Dr Hood did not have a mental disorder and that his personality, while unusual, was not disordered and he did not fulfil the diagnostic criteria for a recognised mood disorder.

3.18 She concluded that Dr Hood corresponded to a hyperthymic temperament with traits of over confidence and extroverted behaviour with action orientation. She said undue risk taking can bring such people to the brink of ruin, particularly financial ruin. There are no specific treatment recommendations for such a condition and none are suggested by Dr McCarthy for Dr Hood. Dr McCarthy accepts that the relationship difficulties with Dr A were a significant stressor as were the difficulties in their business partnership.

3.19 Dr McCarthy had no medical recommendations to make in the case and she said there was a risk of further depressive episodes. She said she had some difficulties in understanding the extreme nature of his response. Dr McCarthy appended a text book extract on the hyperthymic temperament in which it was suggested individuals with this temperament are not inclined to any type of self-examination and that their hypertrophied sense of denial makes them poor candidates for psychotherapy. She said she did not think there was a high risk of repetition against Dr A.

3.20 Professor Healy, Professor of psychiatry, was instructed by Dr Hood's solicitors to prepare a report on the effects of Prozac, but concluded there were no grounds to suggest that his intake of fluoxetine significantly contributed to the incident.

3.21 Dr Holloway, Consultant psychiatrist, was instructed by the GMC to consider Dr Hood's fitness to practice. In a report dated 25 May 2011 she too concluded he does not suffer from a mental illness or personality disorder. She concluded Dr Hood may respond to stress in the future by developing an adjustment disorder, but she could provide no mental health explanation for his behaviour in relation to the index offence. She does not suggest any treatment as being appropriate and she does not offer a prognosis.

3.22 Dr Sillince, Consultant Psychiatrist, was also instructed by the GMC to consider Dr Hood's fitness to practise in a report dated 20 April 2011. She accepted there had been a number of stressors in the period leading up to the incident in August, but could not conclude Dr Hood was depressed at the time of the index offence. She does conclude that it was probable Dr Hood was suffering from an adjustment disorder, but that this diagnostic description did not, in her words, do justice to the extreme state of the emotional dyscontrol and anger at the time of the offence.

3.23 She states he was probably in denial about the extent of his distress or has a difficulty in recognising and naming emotions. She finally concludes he could be said to be suffering from category F43.8 under the ICD 10 classificatory system (reactions to severe stress. She describes this category as a 'ragbag to describe conditions which fall out with the cracks.' She does not accept Dr Hood has a personality disorder and does not suggest any treatment or prognosis.

4. Consideration by the Tribunal

4.1 We considered whether the grant of a national disqualification was warranted and was proportional. We accepted the circumstances surrounding the offence were serious. Dr Hood had perpetrated a premeditated and planned attack on Dr A in her own home. He had armed himself with an axe and petrol and wrongfully let himself into the home. He had continued with the attack even though he was aware Dr A's children were in the house. He had issued threats in front of the children. He had terrified the children and Dr A, making them believe he intended to kill Dr A.

4.2 He had caused petrol to be put on the floor. He had chased the three out of the house and thrown an axe. We accepted Dr Hood's basis of plea of an intent to frighten but we concluded the fear engendered had been extreme, and inflicted not just on Dr A but on her children also. Further by his reckless acts with the petrol he had created a significant risk of fire in the home at a time when children were in the house. We accepted the incident was very serious.

4.3 We considered his explanations and whether he had shown insight into his actions and whether his actions had been remedied. We accepted that there were a number of stressors in Dr Hood's life at the time of the incident. His depression had abated and his son appeared to have recovered from his illness, but it appears he was still stressed by the breakdown of his personal and business relationship with Dr A. Further he was stressed by financial difficulties and by the PCT's apparent intention to void the APMS contract. These stressors are of course essentially self-generated by Dr Hood.

4.4 We considered the psychiatric reports. We noted the absence of mental illness or personality disorder. We noted the reference to hyperthymic temperament and to adjustment disorder and we noted that none of the psychiatrists had suggested any particular form of treatment. Indeed we noted from information from Dr McCarthy that Dr Hood may be a poor candidate for psychotherapy. None of the psychiatrists had suggested a prognosis.

4.5 Because Dr Hood had not submitted a response and had withdrawn his opposition to the application for a national disqualification, we had little information on insight or what remedial steps if any he was taking. We did not draw an adverse inference from this lack of information but neither were we able to conclude that full insight was present and that the behaviour had been remedied. We noted that he had shown very little insight during the incident itself and had apparently failed to appreciate the seriousness of the matter by believing he would not be held in custody.

4.6 He had pleaded guilty at the earliest opportunity (albeit in the face of overwhelming evidence) and he had apparently sought to blame external factors such as stress from workload without apparently accepting his own responsibility for creating those stressors. It may be also that some of the stressors were somewhat exaggerated by Dr Hood. In any event we did not find evidence to suggest that Dr Hood had shown the necessary insight into his

actions. Neither was there evidence to suggest his behaviour could be remedied or that he was seeking to remedy it. We did not find evidence that a repetition of such behaviour was not possible. Indeed Dr Sillince said he was in denial and Dr Holloway said he may respond in the future to stress by developing another adjustment disorder.

4.7 We accepted that the incident was not merely local as the behaviour was personal to Dr Hood and could occur in any part of the country. We considered if a national disqualification was a proportionate response and concluded that it was. This was because of the seriousness of the incident, the risk created and the lack of evidence to suggest insight, or that there had been remediation or that there was an absence of risk of repetition. For these reasons we granted the application for a national disqualification.

4.8 We considered whether the length of period before which an application for a review can be made should be extended under rule 19 of the 2008 Rules to 5 years but concluded this would not be appropriate. In the absence of clear evidence about insight and remediation we could not form a clear judgement as to the prospects of success of such an application. The matter should be left to the tribunal which considers the application should one be made.

We ordered

1. That an order for national disqualification from any of the lists set out in Regulation 18(1) of the 2004 Regulations be made in respect of Dr Hood.
2. No order to be made under Regulation 19 of the 2004 Regulations.

John Burrow

Judge HESC/PHL

22.8.11