Primary Health Lists

The Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care) Rules 2008

[2018] 3386.PHL

IN THE MATTER OF THE NATIONAL HEALTH SERVICE (PERFORMERS LISTS) (ENGLAND) REGULATIONS 2013

Heard on 25 February, 1 July, 26 November, 27 November, 10 December and 12 December 2019 at The Royal Courts of Justice, Strand, London WC2A 2LL

BEFORE
Judge Debra Shaw
Dr Howard Freeman (Professional Member)
Mr Michael Cann (Specialist Member)

BETWEEN:

Dr Saibal Kumar Hazra

Applicant

-v-

The NHS Commissioning Board (known as NHS England "NHSE")

Respondent

DECISION

The Appeal

1. This is an appeal by Dr Saibal Hazra ("the Appellant") made pursuant to Regulation 17 of the National Health Service (Performers Lists) (England) Regulations 2013 ("the 2013 Regulations") against a decision made by the Performers List Decision Panel on 05.06.18 (confirmed in a letter dated 11.06.18) to remove him from the NHS Performers List pursuant to paragraph 14(3)(b) of the 2013 Regulations, that the continued inclusion of his name on the Medical Performers List would be prejudicial to the efficiency of the services that those included in that Performers List (PL) perform.

Attendance

2. The Appellant was unrepresented at the hearing. He gave oral evidence on his own behalf, but he did not call any witnesses to give oral evidence.

3. The Respondent was represented by Mr Guy Micklewright of Counsel on 25.02.19, Mr Peter Lownds of Counsel on 01.07.19, and Mr Gavin Irwin of Counsel on 26.11.19, 27.11.19, 10.12.19 and 12.12.19. The Respondent called Dr Kheelna Bavalia (Associate Medical Director at NHSE and a practising GP) as a witness.

The Hearing

4. The hearing took place on 25.02.19, 01.07.19, 26.11.19, 27.11,19, 10.12.19 and 12.12.19 at The Royal Courts of Justice, Strand, London WC2A 2LL.

Background and Chronology

5. In August 2016 the GMC informed NHSE that they had received a complaint from a member of the public which raised concerns about Dr Hazra's fitness to practise, as a result of which the GMC conducted an investigation. The concerns related to the management of a 16 month old child that subsequently died of sepsis. This became the index case, which triggered a check by NHSE to ascertain if there had been any other complaints against Dr Hazra.

6. NHSE's records indicated that Dr Hazra had also been subject to 3 other complaints as follows:
   (i) in April 2016 NHSE received a complaint from a patient ("AP") which stated that Dr Hazra lacked empathy and had poor communication skills
   (ii) In June 2016 the GMC received a complaint from a patient ("RY") regarding the prescribing of an incorrect dose of medicine. As this complaint did not meet the threshold for GMC investigation, the matter was passed on to NHSE to review.
   (iii) In August 2014 NHSE received a complaint from a patient ("RA") regarding the prescribing of an inappropriate medication in pregnancy.

7. Given these complaints, and in light of a meeting between NHSE and Dr Hazra on 05.12.16, which gave rise to concerns around his clinical practice and insight, NHSE commissioned a records review to evaluate his standard of care.

8. Dr Aneesha Noonan (an independent GP with no connection to Dr Hazra's practice) reviewed a random selection of 30 patient records from his practice for the period between February 2016 and February 2017. This review raised concerns in relation to Dr Hazra's ability to provide clinical care to an acceptable standard, e.g. key assessments were missing, there were issues in relation to treatment and management of patients, his rationale for prescribing was not clear and, on occasion, demonstrated potentially harmful prescribing, and there were no improvements despite Dr Hazra having been informed of deficiencies in his record keeping following the concerns raised to the GMC in relation to the index case in August 2016.

9. The reflections on this record review which Dr Hazra submitted to NHSE on 30.06.17 and 07.07.16 were not deemed adequate, leading to Dr Bavalia and Graham Boullier (Head of Practitioner Performance and Revalidation at NHSE) meeting with Dr Hazra on 07.09.17. Dr Hazra was supported by Julie Sharman (an LMC representative). He was unable to demonstrate he understood the nature of the

concerns, or the extent of the issues that placed patients at risk, or the role of a supervisor to support his remediation, or to explain how he had learnt from previous complaints and how that had led to a change in practice despite working with colleagues to support him. His approach to learning was largely framed around finding a supervisor who would be able to highlight the issues and tell him what to do. Given Dr Hazra's inability to self-evaluate, his lack of insight into the issues and learning needs, and his lack of understanding of the role of a supervisor, he was not deemed suitable to work with a supervisor and a remediation plan was not implemented.

10. During this time the GMC was also conducting its own investigation in relation to the concerns referred to it, which resulted in Dr Hazra being made subject to an Interim Conditions of Practice Order. One of the conditions imposed was that Dr Hazra was to work with a supervisor approved by NHSE. Given NHSE's above concerns, it refused to approve the appointment of the supervisor that Dr Hazra had identified, particularly as that supervisor would not have been working in the same practice. This meant Dr Hazra was unable to continue in practice.

11. The GMC also conducted a professional Performance Assessment ("PA") between October and December 2017 as part of their investigation. The PA reported deficiencies in relation to Dr Hazra's standard of care; namely his clinical assessments of patients, his record keeping, his OSCE examination was significantly below the benchmark, and he was unable to apply his knowledge to his work. In addition, his responses were out of line with current guidance, and his reflection lacked insight, with him responding inconsistently to feedback and lacking clinical and professional ownership of the issues raised. The PA concluded Dr Hazra was fit to practise on a limited basis.

12. Dr Sharma (Dr Hazra's practice partner) covered his patient list whilst he was unable to work. In July 2017 she raised concerns with NHSE regarding the standard of care he had been offering his patients, which had become apparent to her whilst covering for him.

13. Given NHSE's view that a supervisor would not sufficiently mitigate the risk to patient safety, it referred Dr Hazra to a Performers List Decision Panel ("PLDP"), which convened on 07.12.17 to assess Dr Hazra's ability to remain on the PL. This PDLP hearing was adjourned as there was considered to be insufficient evidence to satisfy the criteria for removal at that stage, and Dr Hazra was suspended under Regulation 12(1)(b) on an interim basis, to allow NHSE to undertake some further investigations into:
    (i) Dr Hazra's cognitive abilities
    (ii) Concerns raised by Dr Sharma
    (iii) To allow a GMC PA to take place
    (iv) Dr Hazra's indemnity status.

14. Dr Hazra underwent an Occupational Health ("OH") assessment by Dr Ali Hashtroudi on 27.11.17. Dr Hashtroudi indicated this raised some concerns about potential cognitive decline, and recommended an in depth neuro-cognitive assessment. This assessment was carried out by Dr Namja Khan-Bourne (Consultant Clinical Neuropsychologist) on 29.12.17, who concluded Dr Hazra's pattern of performance was suggestive of a weaker performance on tasks reliant on language skills. Dr Khan-Bourne indicated he would defer to a consultant neurologist regarding the presence of any underlying neurological impairment, but suggested it might be worthwhile to assess Dr Hazra's English language proficiency in the context of his

visual difficulties due to cataracts, and the possible effect of translating, given English is his second language.

15. Dr Hazra sat the IELTS English language test on 07.04.18, but only obtained a score of 6 rather than the requisite score of 7.5. (He has subsequently sat it on several other occasions, but been unable to attain the requisite score.)

16. Dr Hazra also underwent a further OH assessment by Dr Hashtroudi on 22.05.18. He concluded that Dr Hazra's hearing loss and sight impairment did not impact on his ability to practise, but that Dr Hazra remained medically unfit to practise at that stage due to impaired cognitive functioning.

17. The PDLP was reconvened on 05.06.18. It determined that Dr Hazra should be removed from the PL pursuant to paragraph 14(3)(b) of the 2013 Regulations, i.e. on the basis that the continued inclusion of his name on the PL would be prejudicial to the efficiency of the services that those included in that PL perform. In reaching its decision the PDLP noted that the GMC PA and NHSE's review of Dr Sharma's concerns closely correlated with NHSE's original findings, and that the triangulation of evidence provided by three independent sets of reviewers highlighted that Dr Hazra's clinical performance fell seriously below the standard expected of a Practitioner on the PL. The PLDP stated that it remained very concerned about Dr Hazra's health, and noted that whilst the neuro-psychological assessment was inconclusive, Dr Hashtroudi had been clear that Dr Hazra was medically unfit to practise at that stage because of impaired cognitive function. Although the PDLP noted Dr Hazra's poor communication in its broadest sense was a theme in all of the reviews of his clinical practice, it confirmed it had placed no direct weight on Dr Hazra's score in the IELTS English language test as it is not a requirement for performers already on the PL.

18. Dr Hazra lodged Notice of Appeal with the First-tier Tribunal (FTT) under Regulation 17(1) on 05.07.18.

The Law

19. The legal framework for this appeal is largely contained in the 2013 Regulations which, inter alia, set out the criteria by which appeals are to be considered.

    19.1 Regulation 14(3)(b) provides that a Practitioner may be removed where his continued inclusion in the performers list would be prejudicial to the efficiency of the services which those included in that relevant performers list perform ("an efficiency case")

    19.2 Regulations 15(5) and (6) set out the matters to which NHSE (and the FTT) should have regard in an efficiency case including, inter alia:

    (a) the nature of any incident which was prejudicial to the efficiency of the services, which the Practitioner performed;

    (b) the length of time since the last incident occurred and since any investigation into it was concluded;

    (c) any action taken by any regulatory body or other body as a result of any such incident;

    (d) the relevance of the incident to the Practitioner's performance of the services which those included in the relevant performers list perform, and the likely risk to patients or to public finances.

19.3 Regulation 10(1)(b) provides that where NHSE considers it appropriate for the purpose of preventing any prejudice to the efficiency of services which those included in the relevant performers list perform, it may impose conditions on a Practitioner's continued inclusion in such a list.

19.4 Regulation 17 provides that the appeal to the FTT is by way of redetermination, and the FTT can make any decision which NHSE could have made.

19.5 The burden of proof of an issue is on the party who alleges it and the standard of proof is on the balance of probabilities.

Preliminary Issues

20. The FTT was asked to admit additional evidence from both parties at various stages of the appeal. In considering the admission any late evidence, the FTT applied Rule 15 of the Tribunal Procedure (First Tier Tribunal) (Health Education and Social Care Chamber) Rules 2008 ("the 2008 Rules") and considered the overriding objective as set out in Rule 2. The FTT admitted all late evidence agreed between the parties, on the basis its admission was relevant to the issues in dispute.

21. At the hearing on 25.02.19 there was a discussion as to whether the case being presented to the FTT was purely an efficiency case, or whether it also encompassed suitability. However, by the time the FTT heard the substantive case (commencing on 26.11.17), NHSE was represented by different Counsel, who relied solely on grounds of efficiency.

22. This hearing was also adjourned until 01.07.19, with directions to ensure that Dr Hazra was provided with access to all relevant medical records, and the opportunity to file and serve a witness statement in support of his appeal in relation to any findings relating to those records.

23. Dr Hazra appointed a representative prior to the reconvened hearing scheduled to take place from 01.07.19 to 03.07.19. However, just before the hearing was due to commence, this representative e-mailed the FTT to seek a postponement, as she was unwell and likely to be contagious for three days. Counsel for NHSE had no objection to such postponement and the hearing was therefore adjourned and re-listed for 26.11.17, 27.11.17, 10.12.19 and 12.12.19. Dr Hazra's representative subsequently informed the FTT she was no longer representing him, and he was unrepresented when he appeared before the FTT for the substantive hearing.

24. Throughout, the FTT sought to accommodate Dr Hazra's status as a litigant in person by giving clear indications before any breaks in the hearing as to what would be expected/required of him when the hearing resumed, and by regularly checking to ensure that he understood the FTT's procedures and the issues and evidence that were being raised. It ensured that regular breaks were taken, that additional breaks were taken when it appeared that Dr Hazra needed a little more time to prepare and/or consider any issues, and allowed him to submit and rely on late evidence. Mr Irwin was also very helpful in assisting Dr Hazra at the substantive hearing, e.g. by ensuring that up to date copy bundles were available to him during the hearing, by helping him to find the relevant page numbers in the evidence bundles, in arranging for copies of his late evidence to be made, and in seeking permission from the FTT to explain to, and assist Dr Hazra with, procedure during the course of the hearing and in any breaks.

25. Mr Irwin helpfully summarised each party's case in closing submissions as follows:

(i) Dr Hazra's case

(a) The PLDP gave undue weight to the report obtained by NHSE at the PLDP's request from his professional partner, Dr Sharma – the contents of which were provided in bad faith due to an ongoing partnership dispute;

(b) Both NHSE's investigation and the GMC investigation into his fitness to practise were unfair and the conclusions they reached were unfounded and/or excessive;

(c) No criticism can be made of his treatment of the 16 month old boy who died of sepsis – the GMC and Ombudsman having investigated and made no adverse findings;

(d) The PLDP's decision was based on Dr Hazra's age and, therefore, discriminatory;

(e) He has suffered financial loss as a result of the initial suspension and subsequent removal, and is entitled to an award of damages from the Tribunal;

(f) He had not previously been informed of the requirement for a doctor's English language skills to be measured as a 'band 7.5' rather than the 'band 6' he had scored and, in any event, his standard of English would only relevant if he were applying for inclusion in the PL;

(g) He does not suffer from any relevant health issues;

(h) While his record-keeping may not accord with modern standards, his clinical judgment and management are not at all impaired; his record keeping could improve with the right supervision;

(i) If only others would assist him in overcoming any apparent deficiencies in his practice, he would not be impaired at all;

(j) He should be permitted the opportunity gradually to retire in an environment where his shortcomings are less relevant

(ii) NHSE's Case

(a) The evidence overwhelmingly points towards current deficiencies in a number of areas of Dr Hazra's service provision, including:
   (i) assessment, clinical management, and treatment of patients
   (ii) medical record keeping
   (iii) safety
   (iv) communication
   (v) English language, both spoken and written
   (vi) insight and remediation.

(b) Dr Hazra's appeal should be refused since the only reasonable conclusion to be drawn from the totality of the evidence and, in particular:
   (i) clear evidence as to his declining health (which, it is accepted, would not, in and of itself, be a reason to remove him from the list)
   (ii) his complete lack of insight as to the effect that such health issues have on his practice and the efficiency of the service
   (iii) his own evidence as to his admitted shortcomings, particularly in relation to communication skills, including record-keeping

(iv) his limited insight as to the effect those shortcomings have on his practice and the efficiency of the service

(v) the risk that he poses to patients through denied shortcomings in relation to his clinical practice and management

(vi) his complete lack of insight as to the effect those risks have on his practice and the efficiency of the service

is that his continued inclusion on the PL would be prejudicial to the efficiency of the service, and removal is the only appropriate, and accordingly proportionate, disposal. No conditions could be imposed that would prevent such prejudice.

(c) Dr Hazra's clinical skills are such that he is not currently competent to provide GP services as a performer without restriction, as evidenced by Dr Noonan's analysis and opinion in relation to the 30 Patient Consultations referred to as Rs1-30 ("the Record Review").

(d) That analysis and opinion was confirmed and elaborated on by Dr Bavalia in evidence before the Tribunal.

(e) Both Dr Noonan and Dr Bavalia are competent and qualified to give such evidence. The weight to be given to their evidence is a matter for the Tribunal. NHSE submitted that such evidence was clear, cogent and should be given considerable weight.

(f) Although Dr Hazra disputed Dr Noonan's and Dr Bavalia's analyses insofar as they related to his clinical practice and management (going so far as to suggest that they had dishonestly orchestrated a campaign to have him removed from the PL, he agreed with them, in part, in relation to their analysis of his record keeping.

(g) Dr Hazra's standard of written and oral English is insufficient to enable him to provide GP services as a performer without restriction. A performer's standard of English is a proper factor to consider when making a decision as to whether his continued unrestricted inclusion on the list is appropriate.

(h) Dr Hazra lacks any, or any adequate, insight into his failings, such that conditions are inappropriate.

(i) There is no evidence whatsoever that the PLDP's decision was based inappropriately on his age and/or any other irrelevant factor.

(j) NHSE does not in this appeal criticise Dr Hazra's treatment of the 16 month old boy ("the index case") whose death triggered the involvement of the GMC and Parliamentary Ombudsman before causing NHSE's Record Review.

(k) NHSE does not submit that Dr Hazra's indemnity cover is inadequate.

(l) NHSE does not submit that Dr Hazra's health, in and of itself, impairs his performance, rather that his failure to understand his deteriorating health and/or make any reasonable adjustment to accommodate it, is powerful evidence of his lack of insight and is relevant to any decision that he is not currently competent to provide GP services as a performer without restriction.

The Issues which the Tribunal considers to be relevant

26. We consider the alleged deficiencies in Dr Hazra's service provision, as revealed by Dr Noonan's Record Review of 30 cases and the 3 other complaints referred to in paragraph 6 above, to be the key issue.

27. We further consider that Dr Hazra's response to the conditions imposed by the GMC may be legitimately taken into account.

28. Turning to the issue of Dr Hazra's standard of English, we did struggle at times to understand what he was saying, and wondered how a patient might manage during a consultation. However, we note and accept that a Practitioner's knowledge of the English language is only a criterion for inclusion in the PL, as opposed to reinstatement to the PL. We also note there was no mention of his English language skills in the GMC's PA (although it did refer to lack of content in some of his referral letters), and that his English was not the cause of any of the complaints against him. Accordingly, we have not attached any weight to Dr Hazra's standard of English, and only considered his communication skills in relation to his record keeping. i.e. if and how any failure to record information in the medical notes could affect his communication with other health professionals who might need to access those notes and treat those patients, e.g. locum doctors or consultants to whom he has made referrals.

29. NHSE relied on deficiencies in Dr Hazra's sight, hearing and cognition. However, we note the evidence that his vision is an issue, is limited to him having made an error when using a drop down menu, and we consider any sight deficiencies are likely to have been rectified by his subsequent cataract surgery. Likewise, we consider the evidence that whilst he might experience hearing problems if there is background noise, this should not impair his ability to work as a GP in a quiet surgery, means his hearing would not be an issue in consultations with patients. So far as any cognitive decline is concerned, we note the most recent clinical report from Dr Naomi Wynne-Morgan (Consultant Clinical Psychologist) dated 14.02.19 indicates it is not possible to say with confidence if Dr Hazra is suffering from a neurodegenerative disorder such as Alzheimer's or Vascular Dementia. Accordingly, we agree with NHSE that Dr Hazra's health, does not in and of itself, impair his performance and, given our above findings, we go further and reject NHSE's submission that Dr Hazra's failure to understand his deteriorating health and/or make any reasonable adjustment to accommodate it, is relevant to our decision and we have not considered it further.

30. We note that Counsel for NHSE confirmed at the hearing on 25.02,19 that NHSE was not relying on Dr Sharma's views. On that date we also advised Dr Hazra that his partnership dispute with Dr Sharma was not an issue within our remit, and we would not attach weight to the allegations in her report.

31. We also note NHSE did not rely on the index case in this appeal and we did not therefore attach any weight to it.

32. We further note NHSE did not submit that Dr Hazra's indemnity cover is inadequate. We advised Dr Hazra at the hearing on 25.02.19 that his indemnity cover was not a relevant issue and we would not be taking it into account.

33. We also advised Dr Hazra on 25.02.19 that the award of damages for any financial loss he suffered as a result of the initial suspension and his subsequent removal was not within our remit.

34. Finally, although Dr Hazra alleged age discrimination as a ground of appeal, he did not provide any evidence, or make any submissions in support of this allegation. In the absence of any evidence on this issue, we did not further consider this allegation.

Evidence and Submissions relating to Dr Hazra's record keeping

35. Over the course of the substantive hearing, which lasted for four days, we were presented with a vast amount of evidence. We have considered all of that evidence, including the written evidence, the oral evidence and the closing submissions at the hearing. We have also had regard to the legislation set out in paragraph 19 above. For the purposes of our consideration of the evidence and this decision, we agreed the best course to adopt would be to identify and then summarize the most pertinent evidence for the key issues in support of NHSE's allegations of efficiency, before fully considering those issues. The fact that we have not specifically referred to all of the evidence does not mean that we did not consider it, but simply that we have restricted our summary of the evidence and the submissions herein to that which we consider most relevant to our conclusions.

36. NHSE relied on 7 examples of the records reviewed by Dr Noonan. Dr Hazra responded to the criticisms of these records and referred to 2 further examples as evidence of what he considered to be good practice. The fact that many examples were not referred to in oral evidence does not mean either that NHSE did not rely on this evidence, or that we did not consider the other records to be deficient, but simply that it was pragmatic to select examples due to time constraints, and we have concentrated upon those examples.

Patient R09

37. The index consultation was on 03.05.16. Dr Noonan criticised Dr Hazra's limited recording of the patient's presentation, and examination only being documented as 'nad', noting there was no neuro- examination on this repeat attendance for dizziness. Whilst there was brief documentation of the management plan and prescribing within guidelines, with investigations appropriately requested, referral to Cardiology after abnormal ECG was delayed and 'for advice only. The Cardiologist commented that the information received was too limited to offer much advice, and it was not clear if that advice was acted upon or if the patient was ever contacted for review. Whilst there was some documentation of advice and follow up to the patient, there was no safety netting. There was no READ code or problem heading.

38. In his response dated 30.06.17 to Dr Noonan's review, Dr Hazra commented that the patient had complained of dizziness for 4 months on 25.04.16, but did not mention missed heart beats or palpitation. Due to brachycardia and continued giddiness he had advised an ECG on 25.05.16, but it was not carried out until 31.08.16. It showed sinus brachycardia and first degree heart block, prompting Dr Hazra to seek specialist advice regarding the heart block and abnormal ECG. He understood or inferred that the ECG itself was not the cause of concern and mostly first degree heart block is not pathological, so he considered calling the patient first to discuss these points with him, and then ordering a 24-hour ECG if needed. He had instructed the receptionist to call the patient for further review on 22.10.16, but unfortunately the patient was not seen until 08.03.17. On that day the patient did not mention giddiness or palpitation, so the various blood tests and 24-hour ECG test as suggested by the consultant were overlooked, but different blood tests including lipids, Vitamin D, U & E, Thyroid and Liver function tests done on 27.04.17 were more or less satisfactory, and although the

patient's giddiness had improved to a great extent, Dr Hazra still arranged a 24 hour ECG on 19.06.17 (results awaited at that time).

39. Having looked at the patient records for the previous 12 months, Dr Hazra explained in his email 30.04.19, that he only wanted the Cardiologist's opinion of the ECG due to the patient's giddiness, as he was more or less sure that the ECG was not concerning, and he had not officially referred the patient to be seen personally. For the same reason he did not chase for a 24-hour ECG, i.e. he did not think the symptoms were caused by a cardiac problem. The Cardiologist had advised different blood tests and a 24-hour ECG afterwards if necessary, which Dr Hazra had not immediately arranged as he did not think it was so important for this patient. He had thought the continued giddiness was possibly from cervical spondylosis, and when he saw the patient on 03.05.16, he had mentioned that his giddiness was slightly better with Stemetil, so possibly Dr Hazra did not examine him neurologically.

40. In her Further Supplemental Witness Statement dated 07.06.19, Dr Bavalia has commented that Dr Hazra's explanation is hard to follow, and his justification for not doing a neurological examination, which would have been appropriate in the circumstances, is difficult to understand.

41. At the hearing Dr Bavalia submitted it was difficult to know what Dr Hazra had discussed with the patient, or on what basis he had decided how to treat the patient, or his management plan. Nor is any further explanation of continued symptoms of giddiness since the last consultation documented.

42. In response to Panel questions, Dr Bavalia did concede that at the prior consultation on 25.04.16, the records indicate a history, examination and prescribed medication are documented, and investigations including blood tests and a neck X-ray are requested, with review and reasonable safety netting documented when the patient was reviewed one week after the IC on 10.05.19, with the patient again being seen and referred two weeks later on 25.05.16, i.e. there was one month between the initial investigation and referral.

43. At the hearing Dr Hazra questioned whether the degenerational changes shown in the patient's X-ray could be the cause of his giddiness, with Dr Bavalia explaining that further exploration of symptoms might have helped to signpost an underlying cause, e.g. neurological or cardiovascular. She also contended that there was an unexplained delay between the ECG carried out on 25.05.16 and referral to the Cardiologist on 27.09.16.

Patient R13

44. The index consultation was on 01.06.16. Dr Noonan criticised Dr Hazra's notes as being very difficult to follow, with it being unclear what had occurred, with no documented assessment of the patient or risk assessment. The follow up consultation [on 13.09.16] appears to switch SSRI back to Citalopram (which the patient had problems with in May 2016) with unclear indication, and Alprazolam, which is not an NHS prescribable medication and only recommended for short-term use, is increased to an unclearly documented dose of '599mg BD'. There is no record of discussion with the patient about switching SSRI, side-effects, or addiction risk of benzodiazepines, or any risk assessment or safety netting for depression. There was no READ code or problem heading.

45. In his response dated 30.06.17 to Dr Noonan's review, Dr Hazra commented that this patient has suffered from depression for a long time, frequently attends the surgery, and is well known to the mental health team (MHT). He had come for a referral to the counsellor as advised by the MHT, as well as for change of medications. He had been getting his prescription and supply of Alprazolam privately from Portugal for a long time with the permission of the local MHT. Therefore, the red flag questions for him were not deemed necessary.

46. The Minutes of Dr Hazra's meeting with NHSE on 07.09.17 record that when asked about the notes making it difficult to know how well the patient was, and to follow the rationale for decision making, drug choice and increased dose of Alprazolam, Dr Hazra commented that red flag questions had not been necessary as nothing was new, although he admitted he had not explored if anything was new. He indicated he would assess if the situation had changed by seeing if a patient looked depressed, e.g. by noting the way they spoke or if they looked withdrawn, but acknowledged these observations had not been recorded. He also said he would manage risk by weaning the medication a patient is on and changing it after a few days if there was any problem. When asked about safety netting he responded he would ask if the patient felt suicidal, but it had not been necessary. He also stated that he gives prescriptions because they help the patient. When asked for further comments for this case, he responded "If you tell me, I will know".

47. In his e-mail dated 25.02.19, Dr Hazra claimed NHSE had been over critical about Alprazolam without knowing the details, with the patient having been started on it in Portugal some time ago, and it having helped him, with him being allowed to continue on it with permission from the local psychiatrist.

48. In his email dated 30.04.19, having looked at the patient records for the previous 12 months, Dr Hazra disagreed with Dr Noonan's criticisms, saying his consultation was self-explanatory and explained on follow-up reply in a clear way. He indicated that he had been seeing this patient maybe once every 2 months for a long time, and his depression was never bad, with him able to be self-caring and reliable on history. On 01.06.16 he did not look different or any worse than on previous times, and Dr Hazra strongly disagreed with Dr Bavalia's comments that he lacked insight and the patient was at risk as he did not document red flag signs or symptoms. The patient had been managing Alprazolam privately from Portugal for many years and varying the dose on advice from the MHT.

49. In a further e-mail dated 15.05.19, Dr Hazra claimed to recollect from memory that the patient had been taking a drug similar to Alprazolam privately from Portugal for many years, with it being approved by the local psychiatrist there in addition to Citalopram or Mirtazapine. The patient had mentioned a few times that he was experiencing difficulties getting Alprazolam in Portugal on a regular basis, so Dr Hazra had prescribed it with permission from his consultant to obtain it privately. It was obvious 599mg was a mistake and the prescription from that consultation showed Dr Hazra ad prescribed 500mg. The psychiatric consultant had allowed the patient to use Alprazolam for a long period, and Dr Hazra would not interfere with specialist advice.

50. In her Further Supplemental Witness Statement dated 07.06.19, Dr Bavalia commented that Dr Hazra has justified not needing to undertake a full assessment on the basis he knows the patient well and the condition is longstanding. He does not seem to understand that the severity of chronic conditions can change, and require an

assessment if the patient presents with symptoms relating to the condition. He seems to imply that it is the responsibility of the MHT to monitor, when it is also his responsibility as the patient's GP. Nor does he appear to understand the reason for recording red flags and their importance, saying he assesses when he believes a patient to be unwell, rather than using them as a tool to assess how unwell someone might be.

51. At the hearing Dr Bavalia submitted there had been a risk concern with this patient as it was impossible to see from the notes what had happened in the consultation, or the rationale behind the prescribing. She had also been concerned at their meeting on 07.09.17 that Dr Hazra did not understand who the responsible doctor was for issuing prescriptions, and just because the patient was also under the care of someone else did not mean there were no red flags. Dr Bavalia did acknowledge that, if the patient's full records were on screen, Dr Hazra should have been able to follow referrals and previous consultations with psychiatrists.

52. At the hearing Dr Hazra queried Dr Noonan's criticism of his consultation on 13.09.16. Dr Bavalia explained Dr Noonan had been criticising his limited assessment in the context of understanding his rationale for changing the medication.

53. In a further e-mail dated 09.12.19 addressed to the FTT, Dr Hazra essentially repeated his reasons for prescribing Alprazolam.

Patient R28

54. The index consultation was on 02.12.16. Dr Noonan criticised Dr Hazra's notes documenting a very brief history, with no time frames or detail of associated features. No examination was recorded, only that the patient declined to remove her veil, with no indication of any offer for her to be examined by a female colleague. There was no record of a working diagnosis or management plan, and it was unclear if the prescribing of Ketoconazole was appropriate without a more detailed assessment, or why a prescription was not issued. There was no record of what was communicated to the patient or a follow up plan, although this was unlikely to be of significant risk to patient safety. There was no READ code or problem heading.

55. In his response dated 30.06.17 to Dr Noonan's review, Dr Hazra commented that the request to see a female doctor should generally come from the patient. He also contended that a medicated shampoo prescription is harmless, and pointed out the patient did not complain of itchy scalp at the next consultation, which indicated the prescribed treatment must have helped her. He would not have issued a prescription if it was cheaper to buy the shampoo over the counter (OTC).

56. The Minutes of Dr Hazra's meeting with NHSE on 07.09.17 record that Dr Hazra felt it was the patient's choice to be examined by a female colleague, and although he had not been able to examine her, he felt the medication was safe and could not cause any harm. He again responded "If you tell me, I will know" when asked further about this case.

57. In his email dated 30.04.19, having looked at the patient records for the previous 12 months, Dr Hazra stated that he could remember this patient strongly refused to fully open her veil, so that he could not examine her at all, resulting in him prescribing non-specific and harmless drugs to help her, which he felt was a better option than her having to wait to be seen by a female doctor. He stated he was not sure if she had said she did not want to see the female doctor (Dr Sharma) or not. He had again seen

the patient when she returned on 24.01.17. He also referred to the previous consultation on 10.11.16 with Dr Sharma, in which he was not sure she had taken the right or sensible steps and asked if the FTT medical member would look into that consultation.

58. In a further e-mail dated 15.05.19 Dr Hazra again alleged inappropriate management by Dr Sharma and asked the FTT to look into it.

59. In her Further Supplemental Witness Statement dated 07.06.19, Dr Bavalia has commented that Dr Hazra appears to have missed the point about signposting a patient to another medical professional to ensure the patient received the necessary care.

60. In his witness statement sent by e-mail dated 21.10.19, Dr Hazra yet again asked for Dr Sharma's consultation style, and the style of locum doctors to be compared to see if his consultation was really much inferior. Whilst he acknowledged slight deficiencies in his record keeping in this instance, he denied he was a safety risk to patients, and asked for the chance to be supervised.

61. At the hearing Dr Bavalia submitted that whilst the risk was low at this consultation, there was little information as to how long this complaint had been going on; the full records indicate eczema was diagnosed in 2002 but no medication was then prescribed, with medicated shampoo being prescribed on 01.02.16 and Dermol (for itchy skin) being prescribed on 09.08.16. Dr Bavalia thought these entries raised further questions about how the patient's eczema was being managed.

62. At the hearing Dr Hazra asked why Dr Bavalia had queried his prescribing of Diprobase and Ketoconazole. Dr Bavalia explained Dr Noonan's concern had been his incomplete assessment, which meant it was impossible to tell whether or not his prescribing had been appropriate.

63. Dr Hazra's evidence at the hearing was that the GMC says GPs should help patients if it does not cause harm, and he had tried to help this patient on that basis. He recalled that on 02.12.16 the patient had been adamant she would not open her veil or see Dr Sharma, but he had failed to record this; Dr Hazra had queried how he could treat her and had felt harmless medication purchased OTC would be the best option. He had told the patient to come back if she did not feel better, but he failed to record this. Whilst he agreed there was no working diagnosis or management plan, he did not accept other criticism as she had refused an examination. When questioned about the records showing this patient had previously had head lice, Dr Hazra responded that she was an intelligent lady and had not mentioned this. He also confirmed that, in future, he would ask the patient to return with a chaperone, but at the time he had gained the impression she did not want to be examined in front of other chaperones; she had said she wanted to go home quickly, so he had prescribed OTC medication. He also denied he had given conflicting evidence, or made up evidence (e.g. he stated in his email dated 30.04.19 that he was not sure if this patient had said she did not want to see Dr Sharma, but at the hearing he submitted the patient had been adamant on 02.12.16 that she would not see Dr Sharma).

64. In a further e-mail dated 09.12.19 addressed to the FTT, Dr Hazra contended that, given he had been unable to examine this patient, he believes he was adhering to Good Medical Practice; the patient insisted on having some medication without opening her veil and being unwilling to return on another day. He had tried prescribing harmless medication, on the basis she would return if she was not better. The GMC

encourages OTC medication rather than NHS prescriptions, and if he had refused to prescribe anything the patient would have complained to a higher authority.

Patient R23

65. The index consultation for this 7 year old child was on 03.10.16. Dr Noonan criticised Dr Hazra's notes as there was a limited history, which omitted details that would indicate severity of presentation in a child. The examination was also limited, omitting key vital sign recording. It was unclear what had been assessed to conclude 'Not dehydrated', and there was no record of a chest examination, or of a working diagnosis, or of a management plan. The prescribing rationale for Salbutamol syrup rather than an inhaler was unclear, and given there was no chest examination, it was unclear whether there was any wheeze. There was no documented history of asthma in the records. Nor had any discussion with parent about follow up been recorded, or any red flag safety netting, or medication use, or conservative management. There was no READ code or problem heading.

66. In his response dated 30.06.17 to Dr Noonan's review, Dr Hazra commented that it appears he examined the child's chest but did not record it as can sometimes happen with any busy GP. The history of the illness was very short, with the child having been sent home from school the same day. The working diagnosis was acute bronchitis but not recorded. He had examined the child's tongue and found him not to be dehydrated. He has found Salbutamol syrup to be easier for parents to administer than an inhaler.

67. The Minutes of Dr Hazra's meeting with NHSE on 07.09.17 record that Dr Hazra had said there sometimes isn't time to document everything "but if you tell me then I will". He had confirmed it was his experience which had prompted his drug choice. In terms of current guidance, he had responded "If nobody told me, how would I know."

68. In his email dated 30.04.19, having looked at the patient records for the previous 12 months, Dr Hazra commented that he has found Salbutamol syrup more useful than inhaler unless it gives side-effects, e.g. shaking, and mothers are advised accordingly. He states that it is obvious he examined the child's chest and took the history of duration of cough, but it was not documented. He adds that apparently the child suffered from bronchitis and came for the first time, so asthma was not mentioned.

69. In a further e-mail dated 15.05.19, Dr Hazra commented that the patient had a history of new episode of cough and wheeze possibly for a few days before 03.10.16, and it was most likely he had examined the child's chest, but mistakenly omitted to record it. He added that the child had previously had Salbutamol syrup 2mg/5ml at least 3 times on different occasions (21.05.13, 27.03.13 and 20.11.13) and had apparently felt better without any side-effects. He reiterated that syrup is easier to administer to children than an inhaler for short time use only, and he felt it was unfair to criticise him for prescribing it.

70. In her Further Supplemental Witness Statement dated 07.06.19, Dr Bavalia has commented that it is not obvious to her that Dr Hazra examined the child's chest, and there is no indication in the notes that he did. She is not aware of evidence suggesting Salbutamol syrup has less side effects than inhaler, and current NICE and BTS Asthma guidelines advise inhaler rather than syrup use, with BNF stating the inhaler route is preferred. In the absence of an asthma diagnosis, inhalers can be, and are, widely used for symptoms of wheeze.

71. At the hearing Dr Bavalia added that the Minutes of Dr Hazra's meeting with NHSE on 07.09.17 highlight his inadequate assessment of this patient and the further concerns raised at that time around Dr Hazra's assessment, management and record keeping; his own lack of insight into those concerns; his expectation other people would keep him up to date (e.g. "If you tell me, I will know"); his failure to implement any learning into practice.

72. Dr Hazra's evidence at the hearing was that he disagreed Salbutamol syrup is risky to prescribe, and parents find it easier to administer than an inhaler. He accepted Dr Noonan's other criticisms, but continued to assert he believes he did a chest examination but failed to record it. When questioned how he could remember this after 3 years, Dr Hazra said it was his practice to examine the chest for cough and wheeze and must have done it. It is not his practice to write much detail, but where, for example, he wrote 'Not dehydrated', it is understood he would first have looked at the patient's tongue. The medical member of the FTT agreed with Dr Hazra that it is easier to give the correct dose using syrup rather than inhaler.

Patient R01

73. The index consultation for this patient was on 08.02.16. Dr Noonan criticised Dr Hazra's notes as there was a limited history of complaint, with no documentation of positive and negative features, or red flag symptoms. Examination notes were limited with no record of vital signs, which could be critical as this is an asthmatic patient who reported feeling feverish. The management plan was not clearly documented, and only intimated by prescribing and a request for bloods, which is not necessarily a suitable investigation. The prescribing of Montelukast in asthma is within guidelines as Step 3, after maximising ICS (inhaler) dose, and it is unclear what is the rationale for prescribing here. Vitamin D is appropriately prescribed within guidelines. There is no documentation of any explanation to the patient about the new medication, follow up arrangements and safety netting for worsening/red flag features for cough. There was no READ code or problem heading.

74. In his response dated 30.06.17 to Dr Noonan's review, Dr Hazra commented that the history suggested worsening of the patient's bronchial asthma. This patient visits him frequently, he does not find her too unwell, she was getting maximum dose of 2 different inhalers, but they did not help. She asked for other alternative therapy and the options were either Prednisolone or Montelukast. The patient preferred Montelukast as she suffers from an acidity problem, and she felt better after this Montelukast therapy.

75. In his email dated 30.04.19, having looked at the patient records for the previous 12 months, Dr Hazra commented that this patient had had a cough for 3 days newly before the consultation on 08.02.16, having been free from cough for 3 months prior to that consultation, which suggested that she had acute symptoms from chronic bronchial asthma. At the index consultation her chest was full of ronchi on both sides, she looked well, and she was not at all breathless. If she had been, Dr Hazra would have taken her pulse, BP, temperature and Peak Flow Reading (PFR). She had also had a satisfactory PFR 6 days earlier on o2.02.16. Dr Hazra did not accept that Montelukast was unsuitable, maintaining that it can be given to relieve the acute symptoms in asthma patients; it had clearly helped this patient, she did not return with the same problem, having previously not found relief with maximum dose of 2 different inhalers. Nor had she wanted Prednisolone due to acidity.

76. In a subsequent e-mail dated 15.05.19, Dr Hazra commented further that the patient had previously been prescribed Montelukast 10mg nocte on 11.11.15 and felt better with it in similar condition. He felt Dr Noonan's criticism was therefore unfair.

77. In her Further Supplemental Witness Statement dated 07.06.19, Dr Bavalia has commented that whilst Dr Hazra references a previous clinical assessment with a PFR 6 days earlier, he does not appear to understand that the clinical condition may have changed and the PFR should be repeated. He has indicated he takes metrics when patients are unwell, without making it clear how he makes that assessment, and if he does not use metrics at the relevant appointment, he cannot determine whether a patient is unwell. There is also a lack of information as to what dose of inhaler the patient was taking, making it difficult to comment if it was at maximum dose. Patient records must always be kept up to date to ensure that any future treating clinician has the most recent information possible in order to determine the most appropriate treatment for that patient. In response to Dr Hazra's e-mail dated 15.05.19, Dr Bavalia responded that he was justifying his prescribing choices based on previous medication used, rather than on current clinical guidance, such as BTS or SIGN Asthma guidance.

78. Dr Hazra submitted in his witness statement dated 21.10.19 that whilst Dr Bavalia's statement was partly true, it was not possible to check everybody with chest symptoms at the surgery, and the patient had not looked unwell.

79. At the hearing Dr Bavalia emphasised that metrics must always be taken when a patient with a history of asthma presents with chest problems. Just because this patient had had 2 recent asthma reviews on 12.01.16 and 02.02.16 (i.e. 6 days earlier) did not mean she should not be further assessed, as she could have deteriorated in 6 days. Moreover, at the moment a change of medication was considered, all the basic tests (BP, temperature, breathing rate, PFR) should have been undertaken as part of the overall assessment in deciding what steps to take on that day, e.g. a PFR for someone who is acutely unwell might necessitate emergency admission to hospital. Dr Bavalia was also concerned there was no record of the increased maximum dose of the patient's inhalers, or of clear advice as to how to manage her asthma if it should return. Nor was there any documentation of the patient refusing Prednisolone, which is an acute, short-term treatment. Even if it aggravated the patient's acidity, it could be managed with different medication, and should not be a reason for not prescribing Prednisolone. Dr Bavalia rated the risks to the patient at this consultation to be quite high, given she had a condition which could rapidly deteriorate, and considered it to be an unacceptable consultation. Moreover, the fact there was no READ code meant there was no easy, quick way of ascertaining if this was a one-off or frequent episode.

80. In response to Dr Hazra's questioning when he mentioned the patient had a peptic ulcer, Dr Bavalia maintained that she would not expect Montelukast to be used acutely as it does not give immediate relief. Given this was an acute exacerbation, she could not comment if a nebuliser would have been appropriate because Dr Hazra had not undertaken a complete assessment. Nor could she see a peptic ulcer mentioned in the problem list in the patient's records.

81. In a subsequent e-mail dated 09.12.19 addressed to the FTT, Dr Hazra disputed the criticisms made by Dr Noonan and Dr Bavalia, contending that they were wrong to suggest Prednisolone rather than Montelukast, when they knew the patient had taken Lansoprazole (to reduce acidity) before and after the consultation date. He continued to maintain Prednisolone it could have had a harmful effect on the patient.

82. At the hearing Dr Hazra submitted he had discussed the patient's cough with her on 08.02.16. She had a past history of asthma for many years and she had been using maximum dose of 2 inhalers, but as they were not helping her, he had substituted Montelukast, which she had taken before. He contended that although Dr Bavalia said this was against NICE guidelines, he felt it was better to avoid the guidelines in this instance as he could not risk prescribing Prednisolone, which he thought would have harmful side effects for someone with stomach problems. When it was pointed out to Dr Hazra that he had prescribed Prednisolone for this patient on 08.09.15 and on 16.12.15 (i.e. about 6 weeks before), he maintained that sometimes you have to try something else; the patient had been prescribed Montelukast on 11.11.15, and she had been very clear that she preferred it, as Prednisolone had caused abdominal pain/discomfort (although this is not documented). However, Dr Hazra did acknowledge it is very important to record the salient features of a consultation, claiming that most of the time he does so, but he had been short of time and his record was slightly, but not very, deficient on this occasion.

Patient R03

83**.** The index consultation for this patient was on 08.02.16. Dr Noonan criticised Dr Hazra's notes as the documentation of history and examination was so brief as to be unfollowable. There was no documentation of positive/negative features of presentation, no vital signs recorded, and no documented assessment of cough in the context of a history of ischaemic heart disease (IHD) and abnormal echo. Nor was there clear documentation of management. Prescribing of Atorvastatin did not appear to be relevant to presentation (appearing to be in response to recently improved lipid levels), and it was unclear why blood tests had been requested. There was no record of any discussion with the patient about prescribing, follow up arrangements or safety netting, or any READ code or problem heading. There was evidence of delegation of tasks appropriately to staff to contact patient regarding results and collecting prescription.

84. Dr Hazra did not initially respond to Dr Noonan's review in relation to this patient, but in his e-mail dated 30.04.19 he accepted that his documentation of history and examination was brief, especially for a history of cough for 1 week, but submitted it was not causing any problems for diagnosis and treatment and he thought other busy GPs would have similar practice. He submitted there is no clear demarcation about the briefness of consultation in minor cases, he had not been warned about it in the past, it was not his practice to include negative findings for minor problems, and he thought it was discriminatory when the majority of over-burdened GPs do this. The patient had mainly come for renewal of his medical certificate for IHD and diabetes, and the cough was a secondary complaint. This patient attended frequently, he did not complain of sore throat or any other problem to suggest other possible factors were causing his cough, so Dr Hazra knew from long experience that he did not need further examination. Dr Noonan criticised his prescribing of Atorvastatin on 25.01.16, but omitted the previously documented history of IHD, coronary artery disease, and coronary arteriography. The initial dose of Atorvastatin in 2015 was 80mg OD prescribed in 2015 had been reduced to 40mg OD due to the side effect of body ache, and the patient sometimes stopped it completely, but agreed to restart with a low dose of 20mg OD, although this was not recorded. He felt Dr Noonan's criticism was unfair, careless and irresponsible, given patients with minor ailments are encouraged to first try OTC medication before going to their doctor.

85. In his witness statement dated 21.10.19, Dr Hazra again submitted that the criticisms made by Dr Noonan and Dr Bavalia were unfounded and highly objectionable, given this patient had had severe IHD in the past.

86. At the hearing Dr Bavalia pointed out that Dr Hazra had accepted his notes were too brief and submitted that without an adequate assessment to elicit key information it was difficult to know how unwell the patient was, or if Dr Hazra had taken appropriate action at the time. He should have recorded what sort of cough it was, if there were any other related symptoms, e.g. temperature, chest pain, breathing difficulties. The records indicate that on 26.01.16 (i.e. 2 weeks before the index consultation) this patient was seen at an Urgent Care Centre with a lower respiratory tract infection (RTI), and it was not clear on 08.02.16 if the RTI had resolved and this was a new problem, or if it was an ongoing problem and the RTI was getting better or worse. Given this patient's co-morbidities, the risk was higher, but there was no indication of the management plan or safety netting. Regardless of whether the patient had primarily come to the surgery for a sick note on 08.02.16, Dr Hazra should have assessed him for his cough. Dr Bavalia also submitted that Dr Hazra's excuse that he had not previously been warned about the brevity of his notes was part of his pattern of excuses, e.g. his propensity to say "If nobody told me, how would I know" or there sometimes isn't time to document everything "but if you tell me then I will". She also queried if his assertion was, in fact, accurate, given he had indicated at their meeting on 07.09.17 that he had previously worked with a supervisor who had raised the brevity of his history taking. However, Dr Bavalia did accept that Dr Hazra's explanation of his rationale for prescribing Atorvastatin was acceptable, although she pointed out that this information was not documented.

87. At the hearing Dr Hazra submitted that the patient had come to the surgery for a sick note on 08.02.16. He also queried at this point and in closing submissions if Dr Noonan's knowledge and experience were appropriate to pass judgment in the context of a practitioner whose methods pre-date even her training, and also questioned her independence, submitting she was shortly after appointed to a higher post with NHSE, possibly as a result of her work on this case. (Counsel for NHSE confirmed that he would obtain a copy of her CV and ask her to attend if necessary).

Patient R18

88. The index consultation for this 5 year-old patient was on 01.08.16, when he presented with 'continuous pain and vomiting after food' for a year. Dr Noonan criticised the extreme brevity of Dr Hazra's notes as no further detail was documented, with examination limited to 'abdomen/chest nad' and without any vital signs recorded that would be critical to assessing patient health. There was no documented management plan for the presenting complaint, and whilst the prescribed Gaviscon was possibly appropriate in the context of presentation, it was not appropriate without other investigations/referrals/assessment. Nor was there any documented discussion with the carer about follow up or safety netting. A Child Protection Conference report proforma was handwritten, brief, and partially illegible and there was no READ code. Nor was there any recorded alert or comment regarding the patient being subject to Child Protection assessment.

89. In his response dated 30.06.17 to Dr Noonan's review, Dr Hazra commented that he had noted the child's abdomen and chest were normal and "apparently the child looked well otherwise I would have noted extra finding of temperature and heart rate, etc." As the abdominal examination did not indicate any lump, he had assumed it was

unlikely to be pyloric stenosis and the child's mother did not mention projectile vomiting. Therefore, the provisional diagnosis was oesophageal related disease, and he had tried Gaviscon first, with the unwritten instruction of coming back after completing the medication dose, and with the idea to refer to hospital for further investigation if required. He had been following CCG guidelines not to refer on the first instance unless really needed to keep the practice referrals low. He submitted this was a grey area and GPs should not be blamed for non-referral on the first instance. He further submitted that the recording of a child as subject to Child Protection assessment is normally READ coded by the summarisers, but he would in future ensure he checked if a READ code and alert were in place, especially when completing a report, and an appropriate READ code and alert had now been added to this child's records.

90. In his e-mail dated 30.04.19 Dr Hazra added that the history was pain and vomiting after food and only after breakfast for 1 year, which gave him the impression the child was not acutely ill, so he had not requested further investigation or referral on that day. The plan was clear but not recorded, i.e. to try Gaviscon first and to return if not better.

91. In a subsequent e-mail dated 15.05.19, Dr Hazra commented that the notes indicate the child was given Gaviscon infant sachet (30) on 22.03.13, and it seems he felt better after that, with him not needing Gaviscon or any other dyspepsia medication after 01.08.16. He submitted this proved further investigation and referral was unnecessary, and Dr Noonan's comment relating to Gaviscon was inappropriate.

92. In her Further Supplemental Witness Statement dated 07.06.19, Dr Bavalia has commented that the patient assessment was incomplete and therefore inadequate, with Dr Hazra basing his judgement on the impression the patient gave, but unclear how that judgement was made.

93. At the hearing Dr Bavalia submitted that continuous vomiting for 1 year is quite uncommon and could have been related to school or medical factors, which should have been further explored. The symptoms could have been impacting on the child's growth and development, and both the underlying cause and the follow up arrangements are unclear from the notes. The notes are unacceptable, giving rise to significant risk.

94. At the hearing Dr Hazra repeated his reason for not immediately ordering further investigations or a referral, but acknowledged there is no record of safety netting. He added that, in his experience, if patients don't feel well, they come back in any event. However, he acknowledged he should have taken more history and taken the child's temperature and pulse or heart rate, but the child had not looked too unwell. When prompted, Dr Hazra further acknowledged he should have asked the child's mother to make another appointment and to bring with the child's 'Red Book' (which records growth etc.) so growth/centiles could be checked at the next appointment, although he contended the child's mother did not report weight loss or poor health. Again, when further prompted, he accepted it was his job to ask these questions, and he should have asked for the Red Book, checked growth, and taken action if it was deficient or asked the child to return in 1 month, and recorded this.

Patient R27

95. Although NHSE did not rely on this patient's records at the hearing, Dr Hazra referred to them as evidence of good practice.

96. The index consultation for this patient presenting with intermittent headache on the right occipital area for one month mainly in the morning lasting 1–2 hours was on 02.12.16. Dr Noonan noted a history of the presenting complaint with a timeframe and some associated features had been documented, but commented it was lacking in some detail, with examination limited to BP, which was high despite medication. Whilst there was a note to follow up/watch and wait headache symptoms, no action or management plan for raised BP was documented. Dr Noonan also queried the undocumented rationale for issuing a repeat prescription for folic acid when there was a normal result in September 2016 and the only history of Vitamin B12 deficiency was in 2012, but not acting on the September 2016 deficient Vitamin D result. She did note follow up advice to return for bloods and if headache unresolved had been documented, although there was no advice for safety netting what the patient should do if worse whilst travelling for 3 months. There was no READ code or problem heading.

97. In his response dated 30.06.17 to Dr Noonan's review, Dr Hazra commented that he had offered this patient a Vitamin D prescription, but he had refused saying he would get plenty of sun in Australia as he was about to travel and stay there for 3 months. Dr Hazra also contended that the patient's 150/90 BP was borderline high, and he was already on Ramipril 10mg OD. As the patient was due to travel to Australia in the next few days, Dr Hazra had not thought it necessary to add other tablets, having advised the patient to see a doctor in Australia if needed, which the patient was happy with. Dr Hazra had continued folic acid on the basis it had been low in the past and the level might drop if it was stopped.

98. In his e-mail dated 30.04.19, Dr Hazra added that the patient was a regular visitor to Australia, where he stayed with his son and would have access to his son's GP or other medical consultation, including BP check-up. He disagreed that medication needed to be increased for BP of 150/90, reiterated why the patient had refused his offer of a Vitamin D prescription, and submitted the records indicated the patient's blood/folate level was intermittently low when he stopped taking folic acid.

99. In his subsequent e-mail dated 15.05.19, Dr Hazra commented further that it would not have been a good idea to increase BP medication when the patient was going away within 4 days. The patient had also indicated he would get his BP checked in Australia.

100. In her Further Supplemental Witness Statement dated 07.06.19, Dr Bavalia has commented that whilst Dr Hazra disagrees with the need for the patient's medication to be increased, he has not provided any justification as to why he thinks this. Nor is there anything in the notes to suggest he has advised, or agreed with, the patient that he should arrange follow up in Australia, which would have been an appropriate course of action.

101. In his witness statement dated 21.10.19 Dr Hazra acknowledged he had not documented the plan or advice after the patient went to Australia, as he had thought this to be unnecessary, and it was the sort of mistake that could have been rectified with the help of a supervisor.

102. At the hearing Dr Hazra submitted Dr Noonan's criticism was incorrect as the patient was already on hypertension tablets with BP of 150/90, which is the upper limit of normal BP, so any further action should wait until the patient had returned to have his BP re-checked. As this patient was going to Australia for a few months, they had

agreed his BP should be checked there. When questioned about his lack of a management plan for the patient's intermittent headaches and why he had not recorded that the patient should see a doctor in Australia if they did not resolve, Dr Hazra responded the patient would have known and other GPs would not have done anything.

103. In his closing submissions Dr Hazra reiterated that BP of 150/90 was too high to justify extra medication.

Patient R30

104. Again, although NHSE did not rely on this patient's records at the hearing, Dr Hazra referred to them as evidence of good practice.

105. The index consultation for this 62 year-old overweight patient was on 04.01.17. Dr Noonan commented that assessment was limited and omitted further detail of time frame of multiple presenting complaints. The examination was limited to weight and omitted vital signs and key systems that could impact on patient safety. There was no documented working diagnosis or management plan, and whilst limited blood tests were arranged, Dr Noonan would have expected wider testing in view of presentation, e.g. full blood count (FBC) and thyroid function tests (TFT) as a minimum. Nor was there any documented rationale for prescribing a laxative, or advice on prescription use, or any record of patient communication or arrangements for follow up or safety netting, which could impact on patient safety for an older patient.

106. In his response dated 30.06.17 to Dr Noonan's review, Dr Hazra commented that this patient is a frequent attender who was advised Loperamide in the past for a long duration, with Kaolin and Morphine mixture then being added for her long-standing diarrhoea. At that time the working diagnosis was not evident, although carcinoma of ovary was one possibility. She had been seen by a gastroenterologist in the past, but no definite diagnosis was given. Dr Hazra prescribed Methylcellulose for obesity (the patient weighed 105kg) rather than as a laxative for diarrhoea, as it had helped her in the past with no worsening side effects. The patient had consulted him on 04.01.17 as she was feeling tired, with new symptoms of body cramps, and she asked for iron tablets. As Dr Hazra felt Vitamin D deficiency was the most likely cause, he ordered blood tests for Ferritin and Vitamin D level only. He did not think other tests, including TFT and liver function (LFT) were so important at that stage.

107. In his e-mail dated 30.04.19, Dr Hazra added that the patient would frequently attend for her long-standing problems of tiredness, body ache, urinary incontinence (since 2012), and dry eyes. There was nothing new to examine as she came for medication she had previously taken. He submitted Dr Noonan's comment about necessary blood tests not done (FBC and TFT) was wrong and unjustified, as white blood cell count (WBC), high blood sugar levels (HbA1c), LFT, kidney function etc were done on 17.12.16, and TFT was done on 16.03.15 and 23.03.17 and normal both times.

108. In his subsequent e-mail dated 15.05.19, Dr Hazra again complained Dr Noonan had managed his case very unfairly.

109. In her Further Supplemental Witness Statement dated 07.06.19, Dr Bavalia has commented that it is difficult to follow what Dr Hazra is trying to say here. The suggested blood tests would be a useful screen for underlying pathology. Moreover, Methylcellulose is not indicated for obesity. She has also pointed out that Dr Hazra's

prescribing was outside of current clinical practice and Kaolin is now considered less suitable for prescribing (BNF).

110. At the hearing Dr Hazra submitted that he had thought he would try Methylcellulose for obesity. It was pointed out to him that although this is an old-fashioned remedy for obesity, the real issue was that there was no record of what he had done other than weighing the patient and ordering very limited blood tests. When asked what her tiredness might indicate, he correctly referred to thyroid, iron or Vitamin D deficiency, diabetes, intra-abdominal problem or a tumour, but went on to say he sees this patient quite often and she had not complained much about any particular problem. It was also pointed out to Dr Hazra that the full records indicated abnormal blood tests on 20.12.16 (which were the subject of a telephone consultation on 22.12.16 but there is no record of what was discussed). Those blood tests did not include a C-reactive protein (CRP) (which can be a marker for hidden cancer or heart issues), and together with the patient's presenting symptoms on 04.01.17, should have led Dr Hazra to investigate with, inter alia, a CRP. Dr Hazra responded that the records showed he had re-ordered a CRP test on 15.03.17, and he thought he could have could have also repeated a CRP test not long before this, but when offered time to go through the records to confirm this, he conceded there was no evidence in support. When it was further pointed out to Dr Hazra that elevated CRP might indicate cancer, he responded that the patient goes to a gynaecologist, he had done many tests on 07.12.16, and the patient was a Muslim lady who did not like being examined. However, he conceded that he had not recorded 'examination offered but declined'. He also submitted that if it was something serious, the patient would have pressured him to do something immediately, and it is sometimes up to patients to say if it is serious.

Evidence and Submissions relating to Dr Hazra's record keeping

111. Following the GMC's formal assessment of Dr Hazra's professional performance after having received the results of NHSE's records review, the GMC assessment team concluded Dr Hazra was fit to practise only on a limited basis and imposed various undertakings to prohibit him from working until he could meet those undertakings.

112. The GMC imposed a bespoke undertaking prohibiting Dr Hazra from working in any post that requires a GMC licence to practice until he has completed and received the requisite scores in an acceptable English language assessment. It also imposed further standard undertakings, one of which required implementation within 3 months of acceptance of the undertakings, which Dr Hazra was required to do by 07.11.18 (and he confirmed to us at the hearing on 25.02.19 that he had done). This undertaking required him to design a personal development plan (PDP) approved by his Responsible Officer (RO), with specific aims to address the deficiencies in his practice specified by the GMC, and to give the GMC a copy of his approved PDP within 3 months of the date he agreed to the undertakings.

113. At the hearing Dr Hazra submitted that when he asked, the GMC had told him that if he was not working, the undertakings would not apply to him. He thought that he could get a job at a private company "as they are not so strict", and he could then have a RO who would help him, but he has to pass an English language test before he can work at all. Given this, he has not dealt with the undertaking relating to his PDP. or undertaken any recent CPD.

114. When questioned, Dr Hazra also admitted he had not shown the GMC undertakings to his appraiser, although he said he had mentioned he was having problems with the GMC. On further questioning, he submitted he was sure his appraiser knew everything about the GMC and NHSE investigations, as NHSE was determined to punish him and would have given her feedback.

115 Dr Hazra also claimed not to remember whether he had declared any of the GMC or NHSE concerns or complaints about him on his 2017 appraisal form, but he was sure he had declared the GMC and NHSE investigations on his 2018 and 2019 forms.

116. He also said he had not developed a PDP with his 2018 and 2019 appraiser which addressed the issues set out by the GMC, as she did not ask for them and he did not show them to her.

Consideration of the Evidence

117. We reiterate that simply because we have not referred to all of the evidence does not mean that we have not considered it. We have chosen to concentrate on the 7 examples of the records reviewed by Dr Noonan which NHSE relied on at the hearing, and the 2 further examples put forward by Dr Hazra, as we also heard oral evidence for these examples and were able to ask questions about them. We have collated and set out in detail the written and oral evidence relating to those examples above.

118. We note there were a few instances where Dr Hazra was able to explain to us the rationale for his prescribing and actions, even though he had failed to record it, and that there were one or two examples of just about acceptable practice and record keeping, e.g. recording a history, examination and prescribed medication, requesting investigations, with review and reasonable safety netting documented, followed by referral for Patient R09, and prescribing Atorvastatin for Patient R03, although he did not document his rationale for doing so.

119. We further note that although Dr Hazra disputed Dr Noonan's and Dr Bavalia's analyses in so far as they related to his clinical practice and management, he agreed with them, in part, in relation to their analysis of his record keeping, and accepted there were deficiencies in the quality of the content and brevity of his notes.

120. However, we are sorry to say that there we were not persuaded by any of Dr Hazra's excuses for these deficiencies, e.g. he repeatedly used the excuse that lack of time meant he had not made a note of what he was sure he had done, or he had overlooked doing what he should have done, or he had missed something, claiming this can sometimes happen with any busy GP, or he thought other busy GPs would have similar practice. and he thought it was discriminatory when the majority of over-burdened GPs do this.

121. Looking at these examples in the round, we find there are repeated incidences of Dr Hazra's failure to document his actions, so it is impossible to know whether, for example, he took a full history, or properly examined, or what was the diagnosis/working diagnosis, or the rationale for his prescribing, or the management plan, or whether he had discussed follow up and/or safety netting. Even when Dr Hazra attempted to point us to evidence of good practice (e.g. patients R27 and R30), we find there is evidence of him placing those patients at risk (e.g. when he failed to re-order a CRP test for patient R30). He was unable to persuade us that the overall conclusions reached by Dr Noonan and Dr Bavalia in any single one of these

consultations was incorrect, or that a similar amount of deficiencies would be found in a similar sample from an average GP.

122. We did not think it was a knowledge issue; when Dr Hazra was asked, or it was put to him, what he should have done, he could say or understand what action he should have taken (e.g. he accepted patient R30's raised CRP level could be indicative of a hidden heart or cancer issue), but he would repeatedly make excuses and say that the patient had looked okay, or had not indicated any new problem, or it was a time issue.

123. Nor was Dr Hazra able to demonstrate that he understood the nature of the concerns, or the impact that his actions or lack of action had, and that he was thereby placing patients at risk, e.g. he would use the fact that, on hindsight, a patient had not come to any harm (e.g. patient R28 for whom he prescribed OTC medication for itchy scalp), or he would claim it was a time issue or, as Dr Bavalia had noted, he would repeatedly say "If you tell me, I will know". and seemed to think a supervisor would be able to highlight the issues and tell him what to do and enable him to return to safe and efficient practice.

124. We also consider that Dr Hazra's failure to make detailed notes and/or document his actions could adversely affect his communication with other health professionals who might need to access those notes and treat those patients. We note, for example, that the Cardiologist to whom Dr Hazra referred patient R09 commented that the information received was too limited for him to be able to offer much advice. Furthermore, Dr Hazra repeatedly tried to justify his actions or lack of action to us by saying he knew a patient well, so he would be able to assess if the situation had changed by looking at the patient, i.e. he implied he could assess the situation without making detailed notes or having to refer to the notes, without understanding the risk this might pose if the patient saw another doctor. We are not sure that he appreciates the need for detailed notes so that any practitioner who views them can see the past history, especially in London where there is such a mobile population. We find that Dr Hazra's communication skills in relation to his record keeping are inadequate.

125. In considering prejudice to the efficiency of the services, we have also taken account of Dr Hazra's response to the undertakings imposed by the GMC in October 2018. We consider his failure to start designing a PDP within the required time period and in breach of the GMC undertakings he had agreed to, show a remarkable lack of insight and inability to reflect on his own practice and shortcomings.

Consideration of the Imposition of Conditions

126. We then turned to consider whether it would be appropriate to impose conditions on Dr Hazra to enable him to continue to be included in the PL, rather than to uphold NHSE's decision to remove him.

127. We note that Dr Hazra has made allegations against almost every professional who has investigated him. This was explored by NHSE's representative at the hearing. For example, in his response dated 30.06.17 to Dr Noonan's review, Dr Hazra questioned Dr Noonan's experience. At the hearing he submitted a more qualified, more experienced doctor should have been appointed to undertake the records review, claiming there were many silly mistakes in her review, her style of examination was not good enough to be a real examiner, and she should not be reviewing GPs with so much experience.

128. He further submitted that, as NHSE employees, Dr Noonan and Dr Bavalia's evidence was influenced by that employment and they were not independent.

129. He also alleged in an e-mail to the FTT dated 26.10.18, that Dr Hashtroudi (doctor appointed by NHSE to undertake OH assessment of Dr Hazra) was part of the orchestrated team in collaboration with NHSE to undermine him and fulfil their own interests, and he submitted at the hearing that he had reported Dr Hashtroudi to the GMC "for the nation's interest" (although the GMC had subsequently confirmed to him that his complaint was not within its remit).

130. Dr Hazra also claimed at the hearing that the father of the 16 month old child that subsequently died of sepsis (in the index case) made up the story to get him into trouble, and he repeated both his allegation of dishonest conduct against Dr Sharma, and his allegation that NHSE officers had imposed the requirement for him to pass an English language test by deception and in collaboration with Dr Hashtroudi.

131. NHSE's representative submitted that these allegations of misconduct against those professionals who were investigating Dr Hazra were disgraceful and raised questions about his probity, and we concur.

132. We also have grave concerns in relation to Dr Hazra's evidence as to what information he disclosed to his appraisers and when (see paragraph 115 above).

133. Dr Hazra's allegations and submissions in relation to those investigating him, and the information he provided to his appraisers led us to question his probity. We also had concerns relating to his credibility, and repeatedly had to remind him he was under oath. For example, when being taken through the patient records, he would frequently claim to remember facts that he had not documented. Given the consultations in question took place over 3 years ago, we do not believe he could have direct memory (always in his favour) of those consultations, e.g. in his email dated 30.04.19 he stated he was not sure whether or not patient R28 had said at the index consultation that she did not want to see Dr Sharma, but at the hearing he submitted the patient had been adamant that she did not want to see Dr Sharma. He also told us he thought he had ordered a further CRP test for patient R30 not long before the index consultation, but when offered time to look through the records to confirm this, he retracted this submission.

134. We were also concerned by Dr Hazra's lack of insight into his deficiencies. He only accepted some deficiencies in his record keeping and failed to demonstrate any genuine or lasting understanding of the wide-ranging deficiencies in his practice, e.g. assessment, clinical management and treatment of patients, and safety. As already mentioned above, we consider his failure to start designing a PDP within the required time period and in breach of the GMC undertakings he had agreed to, also show a remarkable lack of insight and inability to reflect on his own practice and shortcomings.

135. Given our concerns relating to Dr Hazra's probity, credibility, and woefully inadequate insight, we do not consider there are any appropriate conditions which could be imposed that would prevent prejudice to the efficiency of the services counter his meet that inefficiency. that those included in that Performers List perform.

Overall Conclusion

136 We are satisfied as to the accuracy of NHSE's submission that the evidence overwhelmingly points towards current deficiencies in a number of areas of Dr Hazra's

service provision, including assessment, clinical management and treatment of patients, medical record keeping, safety, and insight and remediation. In light of Dr Hazra's inability to self-evaluate and reflect on his practice and shortcomings, his lack of insight into the issues and learning needs, and his lack of understanding of the role of a supervisor, we concur with NHSE's conclusion that it would not be an efficient use of resources to implement a remediation plan or appoint a supervisor.

137. Given the above, together with our concerns relating to Dr Hazra's probity, credibility, and overall lack of insight, we conclude that the continued inclusion of Dr Hazra's name on the Medical Performers List would be prejudicial to the efficiency of the services that those included in that Performers List perform, and that no conditions could be imposed that would prevent such prejudice. We dismiss Dr Hazra's appeal and confirm NHSE's decision to remove him from the that NHS Performers List

Appeal dismissed

Judge Debra Shaw
Primary Health Lists
First-tier Tribunal (Health Education and Social Care)

Date Issued: 31 December 2019