First-tier Tribunal Primary Health Lists

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

[2021] 4488.PHL

Sitting at Birmingham Combined Civil Justice Centre
on 19-21 July 2022
Deliberation by video link 10 August 2022.

BEFORE
Tribunal Judge Trueman
Specialist Member Mike Cann
Specialist Member Dr David Cochran

BETWEEN:

Dr Touseef Safdar

Appellant

-v-

NHS Commissioning Board
(NHS England)

Respondent

DECISION

The Appeal

1. Dr Touseef Safdar ('the Appellant') appeals pursuant to regulation 17(2) of the NHS (Performers List) (England) Regulations 2013 ('the 2013 Regulations') against the decision of the Performers List Decision Panel (PLDP) of 2 December 2021 to remove him from the NHS Medical Performers List (MPL) on the grounds of unsuitability pursuant to regulation 14(3)(d) of the 2013 Regulations.

Attendance

2. The Appellant attended the hearing and was represented by Mr Anthony Haycroft, Counsel, instructed by Jinal Shah of Radcliffes Le Brasseur solicitors. The Appellant's witnesses were Mr Paul Couldrey, Dr Mike Roddis and Ms Victoria Walters. The Appellant also gave evidence. The Respondent

was represented by Mr Andrew Hockton, Counsel, instructed by Katherine Wackett of Mills and Reeve Solicitors. The Respondent's witnesses were Ms Karen Palmer (read), Dr Gopal Sharma (read) and Mr Tom Robinson. The hearing took place in Birmingham and the Tribunal, all parties, representatives and witnesses attended in person save for Mr Couldrey who attended electronically by Cloud Video Platform (CVP).

Reporting Restrictions

3. The Tribunal made an order pursuant to rule 14(1) of the Tribunal Procedure Rules 2008 that there shall be no disclosure or publication of any information or evidence concerning these proceedings which would be likely to lead members of the public to identify any patient of the Appellant's GP practice. For these purposes in this decision, the Appellant's practice will be referred to simply as 'the practice'.

Preliminary matters

Late evidence

4. Mr Haycroft applied to admit as late evidence short witness statements from Dr Victor Gnanadurai and Mr Ryan Nicholls, both dated 7 July 2022 confirming in evidential form letters they had submitted to the PLDP for the hearing in October 2021. He also applied to admit a further supplementary report of Mr Paul Couldrey, dated 13 July 2022. The Respondent did not object to the admission of this late evidence but reserved its position on recalling Mr Robinson to deal with anything arising from it. We considered the evidence to be relevant and that it was fair, just and proportionate to admit it.

Dr Gopal Sharma

5. It was expected at the outset that Dr Sharma would give oral evidence to the Tribunal. However, it became clear on the first day that Dr Sharma had been taken ill and would not be able to attend as anticipated. In the event, he was unfortunately not well enough at any stage in the proceedings to give oral evidence. Mr Hockton therefore applied to have his evidence taken as read. There was no objection to this from the Appellant. The Tribunal considered that it was fair, just and proportionate to allow Dr Sharma's evidence to be taken as read in the circumstances, and we agreed to this. The Tribunal also confirmed that none of the members of the Tribunal had ever sat in a judicial capacity with Dr Sharma, who on occasion sits as a Tribunal member in this jurisdiction.

Ms Walters

6. At the outset of the hearing, it was agreed between the parties that no objection would be taken to Ms Walters giving evidence even though she had not made a formal witness statement in these proceedings, provided her evidence was confined to the matters referred to in the note of her interview with the NHS dated 28 July 2020 (B250). The Tribunal was content to agree to this.

7. References to page numbers in this decision are to pages in the Tribunal Bundle.

Background

8. The Appellant is a GP. He became a doctor in 2003. He has his own sole practice in the West Midlands with about 4000 patients on the register. A number of long-term locum doctors have worked alongside the Appellant at his practice. He has been supported by a team of other clinical and non-clinical staff. The practice is overseen by the Practice Manager, Ms Victoria Walters who has been the manager for a number of years. The practice uses the EMIS Web electronic patient record system provided by the Respondent. It was common ground that the practice does not use the EMIS Mobile version of this software. In light of the way the case has been put and the issues that arise, it is necessary to set out the chronology in some detail.

9. In December 2019 the Appellant was arrested and bailed in relation to a serious criminal allegation. It is important to note that since then, the police investigation against the Appellant has concluded, and in December 2020 the matter was closed with no charges brought.

10. On 5 December 2019 the Appellant signed a voluntary undertaking not to undertake clinical work in the NHS until the issues had been appropriately considered. The terms of this undertaking were that the Appellant would '*refrain from seeing or treating any NHS patients or carrying out NHS clinical work until the outcome of the Performers List Decision Panel*'. The PLDP makes decisions with respect to the inclusion or removal of medical practitioners from the medical performers list, and as to any conditions which may be imposed on their inclusion. Put simply a GP who is suspended or removed from the list cannot do clinical work for the NHS. On 11 December 2020 the PLDP decided to take no action with respect to the Appellant, freeing him to continue working in the NHS.

11. On 9 January 2020, the General Medical Council (GMC) issued an Interim Suspension Order under s.41A Medical Act 1983 which prohibited the Appellant from medical practice for 15 months. As a result, the PLDP also made a mandatory suspension order in relation to the medical performers list, under Regulation 12(1A) of the 2013 Regulations. This was notified to the Appellant by letter on 16 January 2020 though he was made aware of it later in the evening of 9 January 2020. Such a suspension continues to have effect for as long as the Interim Suspension Order itself has effect. The GMC interim Suspension continues, having been extended by Order of the High Court in April 2021 and April 2022. It is presently due to expire in April 2023.

12. On 22 April 2020, the NHS received information from the local Clinical Commissioning Group (CCG)[1] that they had received allegations concerning the Appellant from whistle-blowers. A variety of allegations were made, some of which were dealt with elsewhere, but amongst them were allegations that the Appellant was continuing to work as a doctor whilst suspended and was reviewing blood test results; amending medication; tasking staff to complete patient reviews; and completing prescriptions. It was also said that he was

[1] CCGs have since been abolished and replaced with Integrated Care Boards from 1 July 2022 under the Health and Care Act 2022. To avoid confusion, however, this decision continues to refer to CCGs as they were at the time.

asking for test results to be sent to him and had sent text messages to patients concerning blood test results and prescriptions.

13. The allegations were put to the Appellant by the Respondent in a letter dated 6 May 2020 and he was invited to urgent meetings on 6 and 7 May 2020 to discuss them. The letter had an attachment marked as prescriptions for January and February 2020 and it included a long alphabetical list of medications that it was said had been issued by prescription by the Appellant. At the meetings on 6 and 7 May 2020 the Appellant categorically denied the allegations and said that he has only undertaken work in relation to the financial side of the practice or other non-clinical tasks. He said he would need patient details and dates to prove that he hadn't issued the prescriptions. He also said that the timing of the concerns coincided with a dispute with a member of staff in the practice. On 7 May, with his medical protection representative present, he again denied undertaking any clinical work and said he had worked only on administrative issues and had not been into the office very much. He denied any connection with the prescriptions or the text message service. The Appellant was asked to provide a written response to the concerns. A response was received on 18 May 2020. The Appellant denied any involvement with clinical work, medication amendments, reviewing blood tests or completing patient reviews. He said these were sent to the locum GPs. He did say that it was possible that prior to the suspension of QOF[2] in the lockdown of March 2020 that he had asked reception to ensure patients who were due reviews were contacted. But he did not get involved with specific cases, he said, and this was something reception could do without clinical input.

14. On 14 May 2020 the Respondent indicated that it had again received allegations from the whistle-blowers that the Appellant had had an angry meeting with them since learning of the allegations that he was working whilst suspended and had threatened them, in the presence of the Practice Manager, with being dismissed, and seeking their striking off from their own professional body. This was said to have caused significant anxiety and distress.

15. On 20 May, the PLDP decided that the allegations of working whilst suspended were so serious that it should conduct an investigation into them, and it appointed Dr Mansur Ahmad and Mr Tom Robinson to undertake this investigation. The Respondent's letter of 22 June 2020 said that the Appellant would receive a copy of the report and would have chance to comment in advance of any PLDP meeting. Terms of Reference (ToR) were shared with the Appellant and these indicated that the investigation would be conducted in accordance with the NHS England Framework for Managing Performer Concerns. Controversially from the Appellant's point of view, they also indicated that '*there is to be no contact with Dr Safdar, by the investigation team during the investigation*'. For various reasons the completion of the Investigation was delayed. A copy of the Investigation Report was shared with

[2] The Quality and Outcomes Framework (QOF) is an NHS reward and incentive programme for GP practices based on results of a range of indicators.

the Appellant on 27 August 2020 and his response was requested by 11 September 2020.

16. The report concluded that the Appellant had accessed 641 unique records between 9 January 2020 and 22 June 2020 on EMIS as well as logging into or out of the EMIS system 1019 times. The report concluded that he had accessed 1,169 individual patient records with a total number of patient record viewings of 6793. Because of the numbers involved, the investigation chose to focus on a randomly- selected two- week period and sampled the data in greater detail. As a result, the investigation looked at 99 patient records in the period 30 April – 14 May 2020. The investigation also spoke to a number of staff, though some were no longer at the practice and were uncontactable.

17. A detailed review of the 99 patient records confirmed the report's initial findings: there was no evidence of face to face patient contact; the Appellant had apparently reviewed pathology/ blood test results, actioned or commented on them and amended patient medication- in one case it was said he had texted the patient; he had issued electronic prescriptions or commenced courses of medication and reauthorised ended medication, including controlled drugs such as Zapain and Tramadol and disease modifying anti-rheumatic drug medication, and he had given medical advice to administrators who contacted him. The report included a number of appendices; these included details of the access of the Appellant to the system and to patient records together with basic indications of the activity in patient records (**Appendix 2**) and another (**Appendix 8**) containing a detailed narrative in relation to a number of patients and the activity alleged to have been undertaken by the Appellant. It also identified 6 printed prescriptions which it appeared had been signed by the Appellant. The report contained details of interviews with practice staff.

18. The report noted that other administrative staff in the practice had had access to the Appellant's login credentials and smartcard but did not, at that stage, consider whether this meant any of the apparent clinical activity on the EMIS system was attributable to anyone else. The report concluded that no other clinical staff had access to his account and administrative staff were logging in only to reassign 'tasks' to other clinicians. It concluded that it was 'clearly evident' that the Appellant had been working whilst suspended across the relevant two -week period and that it could 'only be assumed' that he had worked in a similar manner across the whole period considered by the Investigation.

19. The Appellant's solicitors responded to the report on 22 September 2020. They suggested various other lines of inquiry. The report was initially considered by the PLDP at a meeting on 3 November 2020 and it gave the Appellant formal notice under regulation 14(8) of the 2013 Regulations that it was considering removing him from the medical performers list pursuant to regulation 14(3)(d) (the 'unsuitability' ground). In that letter the grounds for the removal were said to be '*Dr Safdar has given clinical advice to a locum GP, accessed and actioned patient test results, issued prescriptions and sent tasks to staff and patients whilst suspended from the List and have* [sic] *acted*

outside the terms of their suspension'. It said that the Appellant's actions posed a significant risk to patients and raised concerns about the Appellant's honesty and probity. The PLDP notified the Appellant of its decision and gave him the opportunity to present his case orally. An oral hearing was listed for 20 and 21 July 2021.

20. In March 2021, before that hearing took place, the GMC told the Respondent that it had commenced a new investigation into the Appellant arising out of additional concerns raised by whistle-blowers that a member of the Appellant's family was on the payroll of the practice but did not work there, and that staff had been told to tell the CQC that this person was on long-term sick leave. The Appellant had been notified of the additional investigation in October 2020 but had not notified the Respondent of this as he was required to do by regulation 9(2)(j) of the 2013 Regulations. This new issue was discussed with the Appellant, but it was decided that no new investigation into the concerns would be commenced.

21. On 9 and 11 July 2021 the practice was inspected by the Care Quality Commission and rated inadequate. The evidence included reference to the fact that a GP smartcard was being kept in an unlocked drawer together with login details. It noted that an information governance review had occurred and staff had had GDPR training. A warning notice under s. 29 Health and Social Care Act 2008 was duly issued.

22. The Appellant filed reports with the PLDP on 13 July 2021 from Dr Roddis and Mr Couldrey in support of his case. The Respondent sought, and was granted, an adjournment of the 20 and 21 July 2021 hearing. The Respondent responded to the filed reports and the hearing resumed on 6-7 October 2021. At the hearing the panel heard evidence from Dr Sharma, Mrs Palmer, Mr Robinson, and from Dr Safdar himself. It also had submissions from both Counsel. During the hearing the PLDP asked the Respondent to investigate to what extent any of the clinical activity in the Appellant's account could be affected by 'Change Task Owner' operations within the system which would demonstrate that the clinical task in question had been passed to another person on the EMIS system. This was undertaken, and formed the basis of spreadsheets before us, notionally at pages C137 and C138. This analysis showed that 682 of the 1445 actions (some 47%) ascribed to the Appellant had been the subject of transfer to another EMIS user.

23. On 2 December 2021 the PLDP issued a 99- page decision in which it decided to remove him from the MPL. Having considered the 99 cases, the PLDP identified 21 cases as involving possible clinical activity, and following detailed analysis considered that 16 of them demonstrated that the Appellant had engaged in clinical work whilst suspended. It also made a finding, relying on its obligation to consider all material available to it under regulation 9 of the 2013 Regulations, that the Appellant had failed to safeguard his NHS smartcard and credentials appropriately.

24. The Appellant now appeals to this Tribunal against the decision of the PLDP. The Respondent relies on 4 key allegations and the finding of the PDLP just

referred to. The hearing before us was a rehearing of the case, not a review of the PLDP decision, as required by regulation 17.

The Agreed issues for the Tribunal

25. The Scott Schedule contained 5 allegations, though at the hearing Mr Haycroft took issue with the last of these saying that it was a finding but not an allegation as it had never been part of the Respondent's case. Nevertheless, it remains an issue on which we need to reach a view and for convenience we refer to it as allegation 5.

26. The issues were:
    1) Whether the Appellant carried out clinical work whilst suspended from the national medical performers list by NHS England;
    2) Whether the Appellant carried out clinical work whilst suspended from the medical register by his professional regulator, the GMC;
    3) Whether the Appellant failed to comply with regulation 9 of the 2013 Regulations by not notifying NHS England of an additional investigation by the GMC in October 2020;
    4) Whether the Appellant has shown disregard for professional regulation on the basis of the three previous allegations; and
    5) Whether the Appellant left his smartcard in an unlocked room together with the passcode for it, which allowed unrestricted access to patient records.

27. In respect of the 3rd allegation, this was admitted prior to the hearing.

28. The Respondent accepted at the hearing that if the Tribunal only found allegations 3 and 5 proved, it would not suggest that these were sufficient in themselves to justify removal from the MPL on the grounds of unsuitability.

29. Underlying the first two allegations in the appeal however were a number of sub-issues which it is necessary for us to specifically consider.

30. The burden of proof in this appeal as was accepted lies on the Respondent to the civil standard of balance of probabilities. We note and agree with the case law, however, that some things are inherently more likely than others, and that particularly cogent evidence is required the more serious the allegation made[3].

The Respondent's position

31. The Respondent's position prior to and at the panel (and before us) was that the use of the Appellant's EMIS credentials to undertake clinical work on and after 10 January 2020 gave rise to an inference that the actions recorded in the system were his- particularly when they involved use of his smartcard. It was said that this clinical work was undertaken in the practice or also remotely. The Respondent relied on the initial assessment of Dr Ahmad and

[3] Counsel referred us, and the panel, to a variety of case law all broadly supporting this proposition including *Home Office v Rehman* [2003] 1 AC 153 HL; *Re Doherty* [2008] UKHL 37 and *Casey v GMC* [2011] NIQB 95.

the evidence of Dr Sharma as to the clinical nature of what had occurred. To the extent it was accepted that administrative staff had access to the Appellant's credentials and login details, it was said that these would not be used by those staff- could not be used by those staff- to make clinical decisions because this would be beyond their skill or role. It was accepted that the administrative staff may have redirected some tasks to other clinicians in the practice using the Appellant's credentials. It was said that all other clinicians in the practice had confirmed that they had not used the Appellant's login or smartcard and it therefore followed that any evidence of clinical activity in the EMIS system could be ascribed to the Appellant unless it could be otherwise explained. The Respondent relied on the 16 cases found proved by the PLDP as evidence of the Appellant working whilst suspended and invited us to endorse their conclusions. An initial suggestion that the Appellant had signed prescriptions physically was abandoned before the panel and not pursued before us.

32. It was said that it was not necessary to demonstrate any motive for the Appellant's actions but to the extent there was one, it was likely to be that he could not let go of his practice.

33. The Respondent said that Appellant had in effect conceded that he had not secured his smartcard or EMIS credentials from misuse and had breached a number of information governance, data protection and professional practice requirements as a result.

The Appellant's position

34. The Appellant's position from the outset was that he had simply not undertaken any clinical activity. To the extent it appeared from the use of his credentials that clinical work had been carried on in his account this was plainly someone else using his access. It was denied he had remote access or that he was regularly in the practice. Before the panel it was said that the admitted access that others had to his account and the use made of it by them was a 'complete answer' to the allegations made. The point was made perhaps less strongly to us. The Appellant's position was that the investigation into the activity on his account was flawed and that the Respondent had pursued it with a closed mind, never seeking the Appellant's responses at appropriate moments, and simply adjusting the thrust of their case against the Appellant as various elements of it fell away or could not be sustained. He said the data supporting the allegations was inaccurate and relied on the evidence of Mr Couldrey in support. The Appellant's submissions drew attention to the inherent unlikeliness, as it was submitted, of him engaging in clinical activity in the way alleged and to the lack of motive for so doing when there were 2 locum GPs picking up the practices' work between them, with the assistance of the other clinical staff. The Appellant's submissions noted that the removal of the tasks assigned via the 'Change Task Owner' process to other clinicians which had only been undertaken at the request of the PLDP removed about 47% of the alleged clinical work said to have been undertaken by the Appellant. The Appellant attacked other elements of the case as inherently unlikely.

35. In relation to the 16 cases found proved by the PLDP the Appellant denied, substantively, that there was any clinical work involved: he said (and repeated in evidence) that the activity relied on was not substantive clinical input but rather simply electronic capturing of apparently clinical decisions and it was said to amount to no more than a '*few clicks of a mouse'*.

36. The Appellant attacked the decision of the PLDP as one that reversed the burden of proof and assumed he had undertaken relevant clinical activity unless he could explain it away. To the extent he had an explanation for the apparent activity in his EMIS account he said that this was likely due to the malice of an unknown actor in the process- and noted that there had been a number of personnel issues in the practice at the relevant time, and that there were evidently whistle-blowers involved throughout, whose role (and own motives) had not sufficiently been considered.

Legal Framework

37. The NHS (Performers Lists) (England) Regulations 2013[4] provide for the maintenance of the medical performers list. The key provisions so far as material, provide as follows:-

9 Requirements with which a Practitioner included in a performers list must comply

(1) Where a Practitioner is included in a performers list, the Practitioner must comply with the requirements applicable to the Practitioner under this regulation.

(2) The Practitioner must make a declaration to the Board if the Practitioner—

…

(j) becomes the subject of any investigation by any regulatory or other body;

…

(3) A declaration regarding any matter under paragraph (2) is to be in writing, given within 7 days of its occurrence and is to include—

(a) an explanation of the facts giving rise to that matter, including those concerned, relevant dates and any outcome; and

(b) copies of any relevant documents.

14 Removal from a performers list

(3) The Board may remove a Practitioner from a performers list where any one of the following is satisfied—

…

(d) the Practitioner is unsuitable to be included in that performers list ("an unsuitability case").

…

15 Criteria for a decision on removal

[4] SI 2013 No 335. Made under the National Health Service Act 2006.

(1) Where the Board is considering whether to remove a Practitioner from a performers list under regulation 14(3)(d) (an unsuitability case), it is to consider—

(a) any information relating to that Practitioner which it has received pursuant to regulation 9;

(b) any information held by the NHSLA about past or current investigations or proceedings involving or relating to that Practitioner, which information the NHSLA must supply if the Board so requests; and

(c) the matters set out in paragraph (2).

(2) Those matters are—

(a) the nature of any event which gives rise to a question as to the suitability of the Practitioner to be included in the performers list;

(b) the length of time since the event and the facts which gave rise to it occurred;

(c) any action taken or penalty imposed by any regulatory or other body (including the police or the courts) as a result of the event;

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

(e) – (g) not relevant.

…

17 Appeals

(1) A Practitioner may appeal (by way of redetermination) to the First-tier Tribunal against a decision of the Board mentioned in paragraph (2).

This is subject to paragraph (3).

(2) A decision of the Board referred to in paragraph (1) is a decision to—

(c) remove a Practitioner from a performers list under regulation … 14(3) …

…

(4) On appeal, the First-tier Tribunal may make any decision which the Board could have made.

38. Regulation 24 broadly provides that a GP in the circumstances of the Appellant may not provide primary medical services unless included in the List. 'Suitability' for the purposes of regulation 14(3)(d) is not defined but has its ordinary English meaning. The terms of Regulation 10 are such that in relation to a removal case on the grounds of suitability, neither the PLDP nor this Tribunal can allow the clinician to remain on the List subject to conditions. The decision must be either to remove, or not.

Evidence

39. The Tribunal received an indexed bundle from the parties of 1345 pages. We also had 6 Excel spreadsheets containing various extracts from the EMIS Web system for the Practice. We do not rehearse the contents of the written evidence as this is a matter of record. We have, however, summarised the

evidence to the extent that we need to for the resolution of the issues we have determined.

40. We had witness statements from a number of witnesses for the Respondent including Ms Palmer, Dr Sharma, and Mr Robinson. Ms Palmer's statement set out the relevant factual background and chronology of events. Ms Palmer was a Professional Regulations Officer in the Midlands region for NHS England. She was involved in the progress of the case against the Appellant. Her statement exhibited a number of documents produced as part of the investigation and during the progress of proceedings up to the PLDP decision in December 2021.

41. The Investigation report completed by Dr Ahmed and Mr Robinson in August 2020 found after a system security audit that the electronic medical record systems (EMIS) had been accessed substantially using Dr Safdar's credentials between 9 January 2020 and 23 June 2020. Patient records had been accessed 6,793 times and 1,169 individual different patient records had been accessed at some point in that period. Access had been via either the use of Dr Safdar's NHS 'smartcard' and pin or a manual login with username and password. Access via either method creates an audit trail in the NHS system.

42. Mr Robinson is an IT and Digital Technical Project Manager with the relevant CCG and provides advice across a range of Information Management and Technology issues. For 5 years he was a EMIS web developer for the CCG and created resources and templates and provider support. So far as relevant to this appeal, his witness statement in these proceedings dealt with his role in the initial investigation ordered by the Respondent into the Appellant's activity in the NHS system, EMIS and his extraction of relevant data in June 2020. Later on, in July 2021 he was asked to provide comments and input on the technical report obtained by the Appellant from Mr Couldrey, and in that context his statement gives detail of the EMIS system and explains how to use and interpret the data extracted in June 2020 contained in a number of spreadsheets. It covers what the information extracted from the system purports to show in terms of the involvement of the Appellant and the activities and the two key locum doctors working at the practice, Dr Jivanjee and Dr Hirani. It explains how the system of issuing prescriptions works.

43. Reference was also made in Mr Robinson's statement to the Prescription Ordering Direct service (**POD**) which was a service managed by the local CCG which supported practices with prescription queries for repeat or acute medication requests. The POD has call handlers and pharmacists and mostly field requests for prescriptions which they send to the GP practice for approval or not. The POD pharmacists (who have their own EMIS logins) will issue some prescriptions themselves if they consider they can, without seeing the patient. This might occur for example if they felt they could reissue an acute cream for a re-flare up of a previous condition. Prescriptions issued in those circumstances by the POD show up as 'entered by' the relevant pharmacist.

44. In his oral evidence, Mr Robinson confirmed the contents of his statement and

the extent of his involvement. He said his initial role had only been to extract data, not interpret it. He confirmed the two methods of logging into EMIS and the need for a CCG device to do so. He said that EMIS web and EMIS mobile were different systems, and EMIS web did not confirm whether access was made remotely or not. He said that even though printed prescriptions would always show as Dr Safdar because he was the 'stamp doctor' holding the budget, the system would record in the 'entered by' field who had, in fact authorised any prescription; and he noted that he had conducted an audit on a number of days and confirmed that Drs Hirani and Jivanjee were using their own login credentials on various days when activity was alleged by Dr Safdar, and these entries showed them as the doctor in the 'entered by' field.

45. He said that he had not removed 'change task owner' data from any of the spreadsheets because his role was to extract not interpret the data. He confirmed that AccuRx was an internal messaging system which sat alongside EMIS and allowed text messages to be sent to patients. He said that the NHS property services had confirmed that CCTV footage of the practice was overwritten after a certain period and had now been lost. The NHS property services had also not provided details of who had accessed the building electronically. He could not remember exactly how many devices were in the practice itself but accepted the statement in the CCG report that 14 devices were found at the time of a desktop refresh in July 2020. As a result of the desktop refresh it was not possible to identify what machine had been used to make any of the relevant entries ascribed to the Appellant's account, though it was accepted that many of them had been used at some point. He confirmed that neither of the laptops issued to the practice in March 2020 had been used for any of the activity showing on the Appellant's account. He accepted that there was no written evidence relating to the return of any laptop held by Dr Safdar but that there should be a disposal certificate if it had been destroyed. A third -party organisation kept details of repair and return but nothing had been obtained from them. He noted that the system did not allow for the rerouting of test results away from the sole practitioner GP: the only way to achieve this was to deactivate the account and notify those labs etc that send results that they are now to be sent elsewhere. If Dr Safdar was unexpectedly absent there was no way to divert these records. However, the change task owner process could notify relevant individuals of outstanding tasks. The practice could have viewed tasks etc using their 'global' access, but they had not done so. He denied that the document at page B383 showed that there had been no remote logins: he said it showed only that the user had not accessed EMIS Mobile, which was not the same thing.

46. We had a copy of the clinical advice case review undertaken by Dr Sharma in October 2020 having taken over conduct from Dr Ahmad. We also had a witness statement from Dr Sharma which was taken as read in view of his illness. He accepted in relation to 6 printed prescriptions, previously relied on by the Respondent also as evidence of clinical practice whilst suspended, that these were all repeat prescriptions and could have been signed by Dr Jivanjee in the surgery. He accepted that these had all been printed by someone logged into the Appellant's account, most likely administrative staff, and left for the locum to sign. As he noted in his statement the key question for this

Tribunal was not whether Dr Safdar's EMIS account was accessed and used, but by whom it was accessed and used. He noted the Respondent's 'starting presumption' that it must be the Appellant, because the relevant rules and procedures in the NHS (and in the general law of data protection) required GPs to safeguard their credentials to access the system, to protect patient confidentiality. He accepted that some administrative staff had access to the system and that this did rebut the presumption in relation to some cases that were administrative, but not in relation to any cases that involved clinical activity. The majority of his statement and the key exhibit then reviewed the 21 cases considered by the PLDP and offered his own views on what was clinical activity revealed by the entries in those cases. In the vast majority he agreed with the PLDP's analysis. He then considered who else in the practice could, or might, have undertaken the clinical work there shown, and considered that there were no other realistic possibilities. The practice did not employ any independent prescribers: two independent pharmacists who worked at the practice at the relevant time were present for only limited periods and had narrowly- focused roles which did not include the kind of activity recorded under Dr Safdar's credentials. He ruled out the possibility of administrative staff or a malicious actor and said that as 16 involved clinical work and 10 involved the issuing of medication as well, administrative staff would simply not have the knowledge or experience to carry out this work. He noted that none of the other medics (including the locums) had access to his account and both locums had confirmed that they had never used the Appellant's login credentials.

47. We had a number of reports produced by Mr Couldrey, or more accurately PCIG Consulting Ltd, who confirmed he was the Data Protection Officer (DPO) for the practice. He had undertaken a compliance report for the practice in 2020 and prepared a number of reports for use before the PLDP and before us. The principal report from July 2021 examined the data supplied by the investigation report, and particularly appendix 2.

48. The principal report said there were unresolved data conflicts and drew attention to some apparently conflicting statements about activity on the account; issues with AccuRx; a lack of cross-referencing to the Change Task Owner data and a failure to take into account the role of the POD. It concluded the data was unreliable. Mr Couldrey drew attention to what he said was a very different pattern of use of the account in the period 6 April – 8 May 2020. In this period he said that the use of the smartcard resumed (whereas previous logins had been manual) and that the logins were for longer periods with increases in the number of patient records accessed. He noted what he said were some unusual uses of the account (for example random timings of activity or filing test results without comment or consultation) and concluded that it appeared aimed at creating a deliberate digital audit trail. In his oral evidence, Mr Couldrey confirmed the accuracy of the reports made. He disagreed that what had been provided was 'raw' data and said that there were errors in the use of Excel and in the extraction method. He noted that he had recommended the removal of the change task owner data in his first report but this had only belatedly occurred. He also criticised the assumption made by the Respondent that if there was evidence

of clinical activity in the two- week period selected that there would be similar activity across the period of his suspension. He suggested that the Respondent might have had various other ways of establishing the identity of the machine logon and whether it was remote using the Active Directory system from Terrafirma who provided IT services to the CCG. These had not been used. He noted that he would expect the Respondent to keep accurate records of its devices. He accepted in cross-examination that he was an EMIS user and auditor but was not an 'expert' in it. He accepted he had undertaken an audit of the relevant practice and accepted that there were data breaches of which he'd previously been unaware. He did not accept that some of his conclusions in his report called into question his independence as an expert or that his conclusion that there had been malicious activity on the Appellant's account was intended to support the Appellant's own case directly. He did not accept that the conclusions of the CCG in their response to his report were entirely accurate or that he had misread the data: he again criticised the data provided as misleading. He repeated his conclusion from this last report both that the screenshot at B383 showed that there was no remote login but also that this could have been completely established by better examination of the VPN records.

49. The CCG responded to Mr Couldrey's report in particular with respect to the alleged data conflicts. The response also noted (C107) that the Appellant no longer had a mobile device, and it had been collected following a reported fault in early-mid 2019. It suggested that the device had been destroyed. It was later contended however that this statement was a quote from Dr Safdar and not an acceptance of this as fact by the CCG (C689).

50. The reports of Dr Mike Roddis, dated July 2021 and September 2021 gave his view that the investigation was flawed, not least in that Dr Safdar had been give no opportunity at the outset or the end to set out his own position and in the assumption made by the Respondent that any and all logins in Dr Safdar's name were by him, even though there was evidence from the practice staff that a number of them did use Dr Safdar's login and smartcard which was available in the surgery. It also assumed that he was working remotely on clinical work. In his oral evidence he confirmed his reports, and said that a flawed investigation called into question the conclusions reached. He accepted that he no longer practised clinically as a chemical pathologist and had not done so for some years. He noted that he had had no further involvement with the appeal since his original reports. He accepted he was not an EMIS expert. He had no direct clinical experience of general practice and did not provide audit reports on clinical records.

51. We had a statement and exhibits from the Appellant who also gave oral evidence. He confirmed he was of good character with no convictions and no live police investigations. He accepted he remained suspended by the GMC but that they had made no findings against him. He again denied that he had undertaken any clinical work and asked why he would do this when he had two locums undertaking the work for him and why if he had, he would undertake such minor activities in the scale of what needed doing on any particular day. He said that what was alleged against him did not make sense

as GP work. He referred to a number of occasions when he was out of the country or ill and therefore could not have undertaken the work alleged on those dates. He noted that of the 1830 prescriptions which it was originally alleged he had issued, this had reduced to 6 and was now 0. He said that he did not accept that in principle there was a difference between an acute and a repeat prescription: he said the same level of clinical care should be applied to both. He referred to a number of the cases relied on by the Respondent and noted that whilst they were alleged to contain clinical activity in fact the record on EMIS contained no such judgments: he referred to the recommencement of anti-depressant medication in case 1 and noted that there was no obvious consultation with the patient in that case to accompany the re-start and that this medically did not make sense and would not happen. He also noted the medicines review in case 15 and said that it did not make sense that the medication review was supposed to have occurred at 14.45 on the relevant day but the medication was reissued 3 seconds later. He queried how any of these activities could really be judged clinical and referred to them as 'just a few clicks of the mouse'. He noted that even had he been undertaking these to boost QOF figures, any audit of QOF would disallow them as they were not complete and full records of the activity supposedly undertaken.

52. In relation to the call to the hospital in case 9 he denied this was him and said a GP would rarely call a hospital personally, it was logistically too time consuming, but that if you did you would call with the records open and would record both what you'd talked about, mention the discharge summary and whether the hospital themselves have looked at the records. Any call would be noted first and the change of medication afterwards- not the other way around as here. He said that the overall oddity of the data made him conclude that it was malicious.

53. He denied that he had left his smartcard or login in the desk as alleged. He said that the smartcards were all kept in the safe and he did not share his login details with anyone. He noted that he did not know that it was in the draw and when he found out he put a stop to its use. The last smartcard login was 7 May 2020. He said that he had since sent updated and remediation smartcard and data policies to the CCG and CQC which had been accepted. He said that the practice manager had reset his account password and that the EMIS auditor had confirmed this recently. He also said it was important not to exaggerate the importance of the smartcard: everything could be done without it except the issuing of electronic prescriptions.

54. He repeated that he had returned a DELL tablet in 2019 and denied having a device that could connect remotely thereafter. He said that he went into the practice 1-2 times per week and would sit with the practice manager. In cross-examination he would not accept whether the evidence of the 16 cases showed clinical activity because he said that whilst some of it might technically represent clinical work it had no clinical content. He denied that he had ever been a remote worker before the pandemic and said he liked to keep work separate. If he needed to work, he went into the practice. If he visited a patient at home, he would take a couple of page key print out, he didn't take a device. He said the suggestion that he was 'working from home' was a

misunderstanding on Joan Cole's part and it was Dr Hirani who was working from home. He said he did do administrative work and would call into the practice from time to time. He said that the laptop roll out had occurred at the start of the pandemic in March 2020 and the CCG had issued 2 to the practice which the practice manager asked him to collect. He had done so and had given one to Dr Jivanjee personally and left the other at Dr Hirani's house as she was shielding. He said they had no other laptops.

55. He said that a conversation with Dr Jivanjee as to benzodiazepines at the end of January 2020 was about the practice policy: Dr Safdar said that the practice had a policy of zero prescription of these, but Dr Jivanjee had asked about departures from that. In relation to any specific patient, he had told him to look at the records because all departures from the policy were documented. He denied giving any specific advice on any patient. He denied issuing AccuRx messages and said anyone could do this from the system in his name. He denied any meeting in May 2020 when he had threatened anyone with dismissal or reporting to their professional body.

56. In response to questions from the Tribunal he said that he had used locum GPs for a number of years as it worked well for both parties. He said when he had been suspended he had not had a conversation with the practice manager about how things would be managed in the aftermath because he was 'not in a good place' and felt embarrassed and ashamed of having been suspended. He said looking back he realised he should have done it differently.

57. Lastly, we had oral evidence from the practice manager Ms Walters. She confirmed the note of her discussion with Dr Ahmad in July 2020 was accurate. She said that she was in the practice when he was suspended and confirmed she had seen him undertake no clinical work since then. She said he would discuss financial issues with her and budgets. She said he had no remote access to the practice system and the devices the practice had possessed before had been returned because they didn't work properly. She could not recall the exact date of this. She said that she had reset the Appellant's password on 10 January 2020 as she had 'global' access and had given the details to her staff. She had also allowed them to use his smartcard. She said that she has been on her own at that point and felt she had no choice: she needed to access the account to pass on tasks. She said that it was clear that any medical tasks would be undertaken by Dr Jivanjee or Dr Hirani. She had used the smartcard to forward tasks to the GPs. She said she had not discussed it with the Appellant because he was stressed and she felt she had to make decisions in the interests of the practice. She said that the smartcard was kept in the safe and it was meant to be returned there, and it was to start with; but at some point a member of staff had left it in an open drawer. Thereafter it was mostly in the drawer. She said that they had used the smartcard to start with but over time had realised they didn't need it to access his account or take steps, and therefore had stopped using it. She confirmed to the Tribunal that the team could undertake 20 or more tasks a day on the Appellant's account sometimes double that. She noted that the POD would also generate prescriptions or they could refer it back to the

surgery in which case it would be sent to one of the GPs for approval. She accepted that the login details had not been provided to the clinical staff.

58. She denied that she or her team had made any clinical decisions, however, and said they could not have advised about stopping or starting medication. She denied that there had been any 'angry' meeting in May 2020 with staff who were threatened.

59. She accepted that when the Appellant came into the practice she did not keep an eye on him the whole time, but said the entrance was opposite her office so he would have to come past her to get to his consulting room. She denied defending Dr Safdar or being unfrank.

The Tribunal's conclusions with reasons

60. As already noted, this appeal proceeded by way of rehearing. We took into account all of the oral evidence given to us and the written evidence contained in the bundle and in the 6 spreadsheets that accompanied it even if we do not specifically refer to it below. We also took account of the late evidence and we had regard to the criteria in regulation 15 of the 2013 Regulations.

Allegations 1 and 2: Whether the Appellant carried out clinical work whilst suspended from the national medical performers list by NHS England and clinical work whilst suspended from the medical register by his professional regulator, the GMC

The quality of the investigation and evidence

61. A key complaint of the Appellant was that the original investigation into the activity on the EMIS system was flawed; the evidence was not 'raw' and had been manipulated, it did not make sense and contained inherent errors. Furthermore, it was said that the Respondent had not followed up reasonable requests to make further enquiries that might have exonerated the Appellant, and it deliberately did not involve him in the investigatory process in breach of the guidance on such investigations.

62. We did not share the Appellant's concern that sufficient 'raw' evidence was not available: appendix 2 to the original investigation report contained details of all login and logout activity for the period and contained tabs to the 99 cases on which specific reliance was placed before the PLDP. We have been able to access and forensically assess that information for ourselves. In our view it was necessarily the case that the Respondent would have to focus on activity in a narrower window in light of the number of times that the Appellant's account and patient records, had been accessed.

63. We did, however, have access to only a partial patient record in any specific case, and we had access to details of medication issued, and the identity of the person 'entering' this onto EMIS for the 99 cases in the spreadsheet notionally at C115. We did not have direct access to any other information on the EMIS system and we were reliant largely on the content of appendix 8 of the investigation and the commentary of Drs Ahmad and Sharma for most

additional detail. We otherwise lacked notes sent to a patient, discharge records from hospitals or information sent by clinics or hospitals or notes about reviews of test results. We only had fuller information about medication, and who had 'entered' it and in what prescription form for the specific medication relied on for the 99 patients. If no allegation was made against the Appellant in relation to medication issued, it was not included in the table.

64. We do find that the NHS investigation was flawed and did not afford adequate opportunity to the Appellant to respond. In a case such as this we would have expected formal statements to have been taken from, at least, Dr Jivanjee, Dr Hirani and Ms Walters in view of their centrality to the clinical and administrative operation at the practice and their ability to explain what was happening on the ground. We did not consider that the information obtained from them was sufficiently detailed so as to allow the Appellant to meaningfully understand or respond to the concerns raised. A case in point is the issue of written and signed prescriptions where we consider that a wider discussion with Dr Jivanjee at an earlier stage might have elicited at the outset an acceptance that the signatures on the prescriptions might have been his rather than the Appellant's; and the important detail that he was regularly asked to (and did) sign repeat prescriptions for patients printed by the administrative staff using the Appellant's credentials and left in the reception office for him to sign. In the event, this information emerged only in August 2021, a year after the initial interview.

65. No patient appointment schedule for relevant dates seems to have been obtained which might have helped to identify if any of the relevant patients were ever seen or spoken to by other clinicians at or around the dates alleged. We consider this, in particular, to be a significant failing because of the ease with which it could have been obtained. We had little evidence to suggest any attempt had been made to check the login accounts of Drs Hirani and Safdar to ever cross-check the details of their own interactions with some of the key patients and whether they ever saw them at, or around, the time of the alleged production of medication by Dr Safdar for them.

66. Likewise, we noted that very little attempt had been made to contact some other key members of the clinical staff, even though they had potentially been involved in some of the cases on which reliance was placed. The original investigation team were given contact details for a practice nurse, Mrs Smith (B213) which they were unable to utilise successfully (B214) because she had already left the practice. But it appears that no other attempt was ever made to contact her despite the obvious route of her own professional body. That was particularly pertinent to case 6 where, as we find below, Mrs Smith was potentially present at a time when Dr Safdar was alleged to have been practising whilst suspended.

67. Like the Appellant we also do not understand why he was never formally asked to respond to any of the allegations made nor offered the chance to explain until *after* the investigation report was concluded. It is notable that the Appellant was informed of the investigation only after this was decided upon on 20 May and not asked to comment again until after receipt of the report on

27 August 2021, at which time he was given approximately 2 weeks to provide a full response. Apart from his initial letter of 18 May this was, as far as we can see, the first opportunity he had to address the detail of the concerns raised. We could have understood a requirement not to speak to the Appellant if there was any concern about evidence or witness tampering; but none has been suggested, and the contents of EMIS were not susceptible to manipulation in that way. That being so, we are unsure why the Respondent did not at least share any initial findings and raw evidence with him at an earlier stage and seek his response to it before concluding the initial report. Had they done so, we consider that the Respondent might have been able to focus their allegations much more succinctly at an earlier stage and would have been able to help the Appellant avoid the errors in the analysis of the evidence that we find were made. As it was, he was simply presented with a mass of EMIS data and essentially asked to explain it. That would have been a reasonably daunting task for a GP who had been present for the last 6 months. For one who hadn't, that presented a formidable exercise.

The evidence of Mr Couldrey and Mr Robinson

68. A considerable amount of time was taken up in the hearing before us considering the evidence of Mr Robinson and Mr Couldrey as to the operation of the EMIS system and what the information derived from it showed. There was a dispute about whether Mr Robinson was technically an 'expert' and questions about whether or not Mr Couldrey also had relevant expertise in the use of EMIS. He was also questioned about his understanding of the role of a Data Protection Officer (DPO).

69. We found Mr Robinson to be a truthful, credible witness. Much of his evidence was essentially factual about how he had gone about extracting the data from Dr Safdar's account or about how the EMIS system worked. We were content to accept his evidence about the operation of EMIS as we had no reason to doubt it given his experience working with the system over a number of years. He was candid that he had not analysed the data at the outset and had not been asked to. He had merely undertaken a download. His role later was essentially to respond to the critique of Mr Couldrey. We accept that he was essentially a witness of fact (as he was tendered by the Respondent): but he was clearly an informed one who had had extensive experience over a number of years working with and developing the EMIS system.

70. The Tribunal was more equivocal in relation to Mr Couldrey's evidence. We accepted that a number of the criticisms of the data made by Mr Couldrey were essentially based on a misunderstanding of what the evidence in appendix 2 purported to show. Whether or not the Respondent could have made it clearer the basis on which duplicate records had been removed, it is obvious that Mr Couldrey's attack there was misguided. But he made some legitimate criticisms about the extent of the failure to corroborate or seek to support the electronic data by reference to wider sources. We were not persuaded that the period of 6 April to 8 May 2020 showed any particular difference in activity and again the premise of this was based on a misunderstanding of the number of patient records accessed. Had Mr Couldrey accessed the right information, as we have, he might rather have

identified some of the recurring issues that occur instead across the whole of the 6 months. Overall, we found that his views were overtly partisan and given the errors in the analysis, we did not find his conclusions persuasive. It is unfortunate that the Appellant made similar errors in formulating his own responses to the allegations.

71. We were unpersuaded that the spreadsheet at B383 showed anything other than that there had been no login to the system via EMIS Mobile. That was not a very startling conclusion in the light of the fact that it was accepted the practice did not have access to the Mobile system. The fact that EMIS can indicate whether there has been Mobile access (as opposed to remote access) we found unremarkable. Mr Couldrey said in his July 2022 report that this spreadsheet 'definitively and irrefutably' proved that the Appellant did not remotely access his account after 1 January 2020. We disagree (and he did not go that far in oral evidence, we noted) but we find that the Appellant did not have access in any event, for the reasons we give below.

General observations on the evidence presented

72. As we said at the hearing, this appeal is a rehearing and it is not necessary for us to consider the PLDP decision in detail, other than to the extent that the Respondent invited us to endorse their findings on the 16 cases. We have therefore largely put to one side questions of the burden of proof applied by them or other procedural questions, though we have borne in mind their methodology in reaching conclusions helpfully set out in the decision itself.

73. We have analysed each of the 16 cases below in some detail. Overall, in our view the Respondent has consistently failed to apply a rigorous enough analysis to the evidence presented by EMIS. It put too much store by the anonymous evidence of whistle-blowers and having found apparent corroboration of the allegations made, essentially treated the case as overwhelming because of the volume and scale of the use of the Appellant's EMIS credentials revealed. In fact, the acceptance by the staff that they had full access to the system in Dr Safdar's name and could move and operate within it essentially 'as' him should have set alarm bells ringing at the outset. Instead, the Respondent pressed on with its case without, in our view, ever really taking stock of the cogency and credibility of what was left. The loss of 47% of the evidence against the Appellant because of the intervention of the PLDP to ask basic questions and the concession of the extent to which some work could be seen to be administrative has left the case against the Appellant as a shadow of its former self and, as we analyse below, has left it incoherent and inconsistent.

74. In our view it was striking that the allegations made in March 2021, that a member of the Appellant's family was involved in essentially fraudulent activity at the practice, was investigated and quickly dropped as being without substance, yet there was no evidence before us that this fact caused the Respondent to ever reflect on the credibility and motive of those providing these allegations. Even in the case that remained before us, the Appellant was required to try and meet allegations of intimidating and threatening whistle-blowers that were unsubstantiated in all key particulars and which

were unsupported by anything other than, as Mr Haycroft submitted, multiple hearsay via emails from the Respondent containing details from unattributed third parties. The allegations were, in any event, completely denied both by the Appellant and by Ms Walters who was also alleged to have been present.

Remote working

75. It was an important plank of the Respondent's case that the Appellant had probable remote access to the EMIS system via a CCG device and could thereby access the system for long or very short periods, at differing times of the day and without being seen by other clinicians working in the practice. Without such a device it was accepted that he could not access EMIS externally. Unless he had such a CCG laptop or tablet, this would very much reduce the opportunity he had to use EMIS and make some of the activity much more unlikely to be him. It was accepted by all parties in the appeal that no one else in the practice had ever seen the Appellant undertaking clinical work onsite and Dr Hirani and Dr Jivanjee said that they had not seen evidence in the system of him having worked with patients either.

76. The Respondent's case on remote working rested on their assertion that Dr Safdar had been given a device in the past and there was no evidence that he had returned it; on him having shown Dr Jinvanjee how to use such a device in the office at one point, demonstrating that he had a device; on a comment made by the practice manager to Ms Cole that he was 'working from home' on a particular occasion; and on a couple of responses supposedly received from him through EMIS including to Ms Cole even when he was not present in the practice. The Respondent said that it was inherently unlikely that a sole practitioner like the Appellant would not have remote access.

77. The difficulty for the Respondent in making this case, however, was that they themselves were unable to provide any evidence to us of what device had supposedly been issued to Dr Safdar, or when, to substantiate this, even though the records of such CCG equipment would be entirely within their control. We were, apparently, expected to take at face value their assertion that he did have a device but not the Appellant's that it had been returned in mid -2019. Mr Robinson accepted in evidence before us that there had been well publicised difficulties with tablets issued by the CCG at the time, many of which had been recalled. How the CCG could be sure his was not one of them was never explained. Ms Walters corroborated the evidence of Dr Safdar that the device had been returned. As the Tribunal Judge put to counsel for the Respondent at the hearing, the Respondent is essentially requiring the Appellant to prove a negative; but does not hold itself to the same high evidential standards.

78. Dr Safdar's solicitors also suggested in their letter of 22 September that the issue of remote access needed to be looked into. The investigator's response was *"no inference has been made to suggest that Dr Safdar did utilise remote access himself, but there is the possibility he may well have done so. This would need to be explored and investigated further. However, it is the access to the systems that have been investigated and not necessarily the location from which Dr Safdar has actually done so*" (B288). Mr Robinson said that

some attempt had been made to identify remote working, which had led to the identification of the relevant MAC addresses. But as none of the devices used were now identifiable, and as the system itself, apparently did not record remote access, the Respondent was unable to demonstrate remote access via any electronic records.

79. Dr Safdar frankly accepted that he had shown Dr Jivanjee how to work remotely using a device, but he said that the device in question was one of two that he had obtained from the CCG in March 2020 and which were intended for Dr Jivanjee and Dr Hirani themselves. He said both GPs took possession of those two laptops and he himself had no other. It was accepted by the Respondent that two additional laptops were issued to the practice and that neither was used by the Appellant. We have considered the evidence of Dr Safdar and that of Dr Jivanjee on this subject. We find that Dr Jivanjee was being shown how to use the device he himself took away, not a third device owned by the Appellant. The record of Dr Jivanjee's evidence supports this. We do not consider it at all likely that Dr Safdar would show Dr Jivanjee how to use a different device, and one he himself was using to illicitly access EMIS.

80. In our view none of the remaining evidence sufficiently supports remote working either. Given that a number of staff were able to and did, use Dr Safdar's account on a daily basis, we do not think that 2 brief messages on the system can carry the weight attached to them. The recollection of Ms Cole may be mistaken and in any event evidence that Dr Safdar was 'working from home' was not evidence that he was undertaking clinical work on EMIS in breach of his suspension. Dr Safdar accepted he continued to work on financial and non-clinical work for the practice. The evidence of Ms Cole captured in the note on B254 is equivocal as to whether the response was contemporaneous to either the request or the absence from the office. Those exchanges of messages were never obtained or put before us. It was accepted that the EMIS system cannot tell whether login has been remote or not; the Respondent cannot demonstrate that the Appellant had a device. We find that the screenshot at B383 showed no more than that there had been no logins via EMIS Mobile.

81. We considered that the Appellant's evidence on this issue was credible and reasonable. But in any event, the burden of proof lies on the Respondent, and in our view they have not shown on the balance of probability that Dr Safdar ever had the ability to access the system remotely after 10 January 2020.

Physical access

82. We turn to consider other access. The Appellant said in evidence that he attended the practice no more than once or twice a week to keep things 'ticking over' and to speak to the practice manager. The practice manager said something very similar- and indicated that the Appellant would sit with her when he came into the practice. Dr Hirani was working almost entirely remotely and did not attend the practice. Dr Jivanjee said that he saw the Appellant also infrequently (the summary of his interview suggested 'every few weeks'). The Respondent's case was that the Appellant could have been

accessing the practice regularly without being seen. But again, the Respondent's evidence on this did not back them up. There was no CCTV footage to substantiate his movements because this had been wiped; the NHS property agency had not been able to supply details of the keypad entry system to demonstrate that he had accessed the practice on specific days, and the evidence of Mr Robinson in any event was to the effect that the main door to the practice was open on the occasions he visited. And we note, again, that this was evidence which the Appellant himself asked the Respondent to obtain, via his solicitors on 22 September. In our view, the Respondent has not demonstrated on the balance of probabilities that the Appellant attended the practice more than the once or twice per week he himself accepted. That being so, we must take this into account when considering the evidence of EMIS, showing near daily, if not daily, access to the system.

The approach of the Practitioners List Disciplinary Panel (PLDP) and the 16 cases now relied on by NHS England

83. The PLDP decision considered each of the 99 cases according to the methodology it helpfully set out in paragraph 5.1.3 of its decision (B20). It focused on 21 of the cases and discounted the other 78 on the basis that they gave rise to no concerns or they 'were likely administrative', noting the point made by the Appellant that the administrative staff were using his login to undertake administrative tasks. In relation to the 21 cases, it proceeded to consider each of them in turn and assess the quality of the act taken on the EMIS system and who would have been likely to have taken it. But the PLDP has considered each case in the abstract. It does not appear as though the use of Dr Safdar's account has been interrogated *chronologically* to see whether the context of activity within specific time periods says anything about the likely identity of the user. That is surprising given that a number of key dates reoccur in the remaining cases relied on.

84. We respectfully disagree with the chain of reasoning applied by the PLDP. The panel in some of its findings asserted that some activity on the EMIS system required the application of clinical judgment and that as a result the person entering the information onto the system at that point must be a clinician. They also reasoned that as a result everything else on that login at that time must necessarily also have been undertaken by a clinician. But in our view, this does not necessarily follow. Merely because something that has been entered onto the system in the Appellant's name *should* be undertaken by a clinician does not mean that any such decision on it was reached at the point of the entry onto the system. In view of the timings on the system which we discuss below we are very doubtful that the actual entry into the system at any given moment *was* made by the clinician who reached any clinical judgments, unless it can be suggested that clinical decisions and signing off of test results can be done in 1- 2 minutes. We also discuss below that some clinical decisions *did* appear to be being made offline, and then entered into Dr Safdar's account- not least the issue of some repeat prescriptions or medication reviews.

85. We have reconstructed what we can of the timeline on some of the applicable

dates. That activity is set out, in part, in the appendix to this decision and it includes reference to a number of the other cases within the 99 that occur in the relevant 2 week period but which have been discounted already by the PLDP as administrative. We accept that the timelines shown by EMIS may not be infallible: we did not have detailed evidence from the parties as to how the times recorded are generated. But it is reasonable to assume that they are not wildly inaccurate and the Respondent has itself, at times, placed reliance on the timing of some activity, including in its response to Mr Couldrey's criticisms of the data. We have therefore assumed some margin of error may be possible, but that the chronological sequencing is right. In our view, the results of that exercise pose some significant difficulties for the case presented by the Respondent.

86. Firstly, a number of the live cases still relied on by the Respondent occur very close in time (in some cases no more than a few minutes apart) to other tasks on patient records which have been conceded to be administrative and which are no longer relied on. That is certainly true of the activity on the account on 4 May 2020, where reliance is still placed on the lab test results in case 5 and the medication in case 20 but which occur only 5 minutes after similar activity on patients 1811 and 502252 which are no longer pursued. Apart from muddying the case made by the Respondent, the difficulty here is that on 4 May there is only 1 relevant login from 1 terminal, between 14.26 and 15.48. Logically, the Appellant must have done all of this, or none.

87. The same is true on 10 April 2020: reliance is placed still on the issuing of Colpermin in case 14 at 14.10 but has been abandoned in respect of the Sertraline issued to patient 8426 only 4 minutes later. Again, there is only 1 login from 1 terminal, between 14.04 and 14.56. Either it is all his work or it is not.

88. It is possible that all of these activities *could* have been the work of the Appellant; but accepting the Respondent's case in respect of some of the live cases requires us also to accept that the Appellant was, at times, when logging in also undertaking essentially non-clinical tasks. The activity on the account also places administrative tasks (and administrative staff) very close in time to some of the key activity.

89. The next issue is the pattern of behaviour revealed. On all of the dates which we have been able to piece together activity there is a consistent pattern of the Appellant's account accessing large numbers of patient records within the space of only a few minutes and taking very rapid action on patient accounts to file results or issue medication without further comment or the recording of any patient contact or consultation. The 5 May 2020 is a good example of this: reliance is placed in case 8 on the issuing of Tamsulosin and Memantine tablets and Duaklir at 16.18 on that day as well as tiotropium bromide inhalation powder capsules at 16.20. But the case made does not explain the context of this prescribing: Dr Safdar's login accessed 10 other patient records[5] ostensibly in the same *minute* as those of case 8 and (in relation to

[5] Those of case 7 (4089), 2910, 502123, 502106, 2808, 1819, 3513, 142, 4418 and 6565.

those records which we can view) other medication was issued too: case 7 was issued with lansoprazole capsules at 16.18; patient 502123 was also given sumatriptan and promazine tablets also at 16.18. Medication was also issued to patient 101 at 16.20. But case 7 had, apparently, been the subject of a Change Task Owner to Dr Jivanjee only that lunchtime with respect to the same medication. And the medication review said to have been completed by Dr Safdar at 16.20 for patient 101 had also been the subject of a Change Task Owner to Dr Hirani at 12.45.

90. Even allowing for some limited inaccuracy in the timings involved, in our judgment, the activity revealed here does not make logical sense. In our view, this is not the electronic footprint of a GP who 'cannot let go' of his practice and who is continuing to tinker in a small way. And the absence of patient interface in any of these cases, and the impossibility of it in the timings revealed suggest to us that this repetitive accessing of large volumes of patient records and immediate prescribing of medication and then moving on is either an administrative tidying up of activity that has happened elsewhere and offline, or it is an automatic function driven by some unknown automated process. It is not necessary for us to resolve that: it is only necessary for us to resolve whether it was the Appellant himself exercising clinical judgment and recording it in the system.

91. In our view it would have been comparatively easy for the Respondent to have cross-referenced these records with the appointments diary for the practice, to see whether this revealed whether any of these patients *had* been seen or spoken to or reviewed by any clinician at or around the relevant times, and on those dates, to further shed light on whether, in fact, there was legitimate contact between the patient and the practice and if so, with whom. As we noted earlier, the absence of this information was unhelpful. We accept that Mr Robinson's evidence revealed that both Dr Hirani and Dr Jivanjee used their own smartcards on some of the relevant dates to issue medication. But it is also accepted that the Appellant has not seen or spoken to any patients since 10 January 2020. The unanswered question, for us, was why anyone would prescribe medicine for any patient in this way at such pace and without reference to the patient, other than in respect of repeat prescriptions.

92. Dr Safdar's own response to the evidence put to him in Appendix 8 tended to focus on the unlikelihood, in his view, of the substantial amounts of time in which he was said to have been logged in, but the very small amounts of (relatively minor) activity undertaken. However, his commentary was based on a misunderstanding of the data in appendix 2, and he made the same error as Mr Couldrey of assuming that the record access without duplicates tab removed *daily* duplicates whereas in fact it was intended to remove *any* duplicate at any time. The full appendix however shows very much the opposite: a near blizzard of access to patient records at least on some of the days available to us, in which medication was issued or results filed on multiple patient records in a very short space of time, all without commentary or seeming patient involvement, sometimes taking less than a minute but at least at sometimes reflecting tasks which had, apparently, been sent separately to other GPs to deal with.

93. With these considerations in mind, we turn to consider the specific cases.

Case 1

94. There was some uncertainty in relation to the date of the alleged activity in question: the PLDP found that the allegation was proved in relation to 29 April 2020, whereas appendix 2 shows that the anti- depressant mirtazapine medication relied on was in fact issued on 30 April. It is not clear to us if the PLDP were, at all times, considering the correct data about the Appellant's activities or whether they had access to additional material and notes of which we were unaware. In any event the activity on this case is odd because whilst the medication is restarted following a gap of some months, there is no clinical note accompanying it of any description. We agree with Dr Sharma that on the face of it, this is evidence of a clinical judgement being made (if not recorded) because this should not simply be re-issued without an assessment of the patient. Other doctors were working on 30 April. However, having regard to the wider activity in appendix 1 on 30 April, we are not satisfied that this is evidence of clinical activity *by the Appellant.* It forms part of a wider set of other activity with patients over a very short period which is equally unexplained.

Case 2

95. This case concerned the viewing and filing of fungal microscopy results and the reauthorisation of medication. However, it is again unclear what the PLDP relied on: the decision refers to medication and results on '16, 17 and 30 April'; but there was no activity in relation to this patient on 16 April, and on 16 March the medication appears to have been authorised by Dr Hirani on a change task owner basis. Medication was clearly re-issued on 17 April but this appears now to be a repeat prescription, and therefore likely dealt with administratively. The test results it is accepted had been received twice, so it is only the test result on 17 April that is likely to represent any genuine clinical activity on this patient's record. We consider it notable that both Dr Hirani and Dr Jivanjee had subsequent contact with this patient- on 27 April and 12 May 2020 when additional medication was prescribed; but they do not appear to have been disturbed by what would have appeared to have been the recent checking and filing of test results by a suspended colleague evident on the system.

Case 3

96. This case concerned the viewing and filing of results of a vitamin D level assessment and a text message sent to the patient on 30 April 2020. The curious thing about this case is that the access to the patient's record on this date is the first since before the Appellant's suspension. The access occurs for barely a minute and is accompanied by no narrative or commentary. It is sandwiched immediately between the filing of the second test results in case 2 above, and the registration of a new-born patient, case 4. We accept that the interpretation of the test results will be a clinical issue, but it is unclear when this will have occurred, given that the access is so short and is not preceded by any earlier access. It is unlikely that the results could have been viewed, assessed and filed in the one minute shown. The coding and recording of the

results, and the texting of the patient could be administrative tasks. It is also possible that the advice given in the text message was a quote from the lab results. We conclude that whilst there has at some point been the application of clinical judgment by someone in relation to these results, the circumstances in which this occurs in EMIS do not satisfy us that it was the Appellant.

Case 4

97. Significant reliance was placed on this case by the Respondent because of the discussion said to have occurred between Dr Jivanjee and Dr Safdar about administering vitamin K for new-born babies (which case 4 was) on 30 April 2020. Having expressed an opinion in the system on this being an issue in which GPs do not normally get involved Dr Jivanjee concluded '*I have cc'd dr ts in case he advises otherwise*'. The message, sent at 12.29 received a reply at 14.44 (though the EMIS schedule we have suggests 14.50) in the following terms: "*advice seems OK to me, besides we don't have any letters/ documents to say baby has been given vit K dose etc*'. The Respondent, via Dr Sharma, relied on this as evidence of 'high level clinical advice', and says that another clinician has clearly checked the notes. Dr Jivanjee confirmed that he had copied the Appellant in out of habit but had been seeking confirmation only that he had not missed a service that the mother could access.

98. In his response to this allegation, the Appellant noted (B535) that staff would ring him and discuss various non—clinical matters and that he discovered later that this had subsequently led to the staff actioning these on the system which he said he stopped once he discovered it. He said that the response given here was made by one of the staff who had apparently contacted him and discussed the question of whether GPs got involved in questions around vitamin K.

99. We have recorded in the appendix to this decision, and mentioned just above, the context in which the response was given, so far as we can see it. The *question* put by Dr Jivanjee was potentially a clinical one, but we are not satisfied that the response was one that came from the Appellant, because of the timing and manner of it. In any event, we respectfully disagree with Dr Sharma about the clinical nature of the response. We consider it to be no more than a statement and acceptance of the general policy of the practice around this issue, not an endorsement of specific clinical decision-making on this patient. We do not accept that this case is evidence of clinical activity by the Appellant.

Case 5

100. The allegation in relation to case 5 was the reviewing and filing of blood test results for HbA1c and TSH levels on 4 May 2020. Dr Sharma noted that whilst it was conceivable that these results could have been reviewed by a practice-base authorised independent non-medical prescriber under strict supervision, there did not appear to be any such person active in the practice. He therefore concluded that this case demonstrated clinical judgment being applied. In his response the Appellant focused on login time and number of patient records accessed and the unlikelihood of him reviewing only 1 of the apparently 18

sets of test results outstanding for review at the time; but he was, as it now appears, looking at the wrong figures for activity on his account that day, in any event.

101. It is evident that the test results relating to diabetes, blood sugar and thyroid activity in this case were normal and whilst even normal results *should* be signed off by a clinician, in our view this does not universally happen. An experienced administrator might do that in some practices. The appendix to this decision below shows the context of the filing of these results, again: it came within a period of time that afternoon when Dr Safdar's account accessed up to 27 patient records in about 20 minutes and where (so far as the evidence available to us shows) medication was issued in a number of cases- including in relation to patients 1811 and 502252, previously relied on by the Respondent, but which the PLDP accepted to have been administrative in nature. Again, in our view it is not clear that clinical judgment *was* ever applied to these test results, even if it should have been; or if it was, it plainly didn't occur at the time of their filing because the time frame of accessing the patient record amongst a large number of others made this unlikely; and the pattern of activity on the Appellant's account at that point is, to us, strongly suggestive of administrative sweep-up.

Case 6

102. The allegation in relation to case 6 is that a course of medication, alfacalcidol, was commenced but not issued, and that a hepatitis B vaccination was issued. Dr Sharma's observation was that whilst someone other than a GP could issue a hepatitis B vaccine, the commencement of alfacalcidol required caution, careful counselling and follow up because of the complications it could cause and the common unpleasant side effects. The Appellant's comments focused primarily on the unlikelihood of having undertaken this work in the context of a practice with a number of other GPs and practitioners, including at the POD, to undertake this work.

103. Having reviewed the material available to us in the spreadsheets at C100 and C115, we consider it highly relevant that the issuing of the hepatitis vaccine at 13.26 on 5 May comes 2 minutes after a change task owner request to the practice nurse, Mrs Lisa Smith. In our view, the placement of the practice nurse so close in time to the vaccination makes it more likely than not that it was her who dealt with the vaccination. This has not been addressed by either party and we are also surprised that the PLDP never addressed this question either. But as we noted above, no contact was ever made with Mrs Smith. Presumably if it had been she could have confirmed, or not, whether Dr Safdar was involved with this patient. We also note from C115 that the issuing of alfacalcidol at 13.02 was described as a repeat prescription. The issuing of the alfacalcidol occurred during a single smartcard login from MAC ending in BA38[6] when, as elsewhere in these cases, the operator of the login was issuing significant amounts of medication to other patients in a short space of time. The patient appears likely to be having specialised treatment of renal disease; it is highly likely, in our view, that the alfacalcidol was prescribed by a

[6] There had been a second smartcard login 1 minute after the first but there was a logout at 12.27.

tertiary provider in the first place, but as we do not have access to the full records it is not possible to confirm this. In any event, the records available to us do not persuade us that this is evidence, on the balance of probability, of clinical activity by the Appellant himself.

Case 7

104. Case 7 concerned the alleged issuing of medication on a variety of dates: the re-authorisation of methotrexate and lansoprazole on 10 January 2020; the commencement of a course of Symbicort the same day; the reauthorisation of co-dydramol on 13 April and of lansoprazole on 5 May 2020. The Respondent's case on this, drawn from appendix 8 and the C115 spreadsheet focused only on the issuing of the Symbicort on 10 January and the issuing of lansoprazole on 5 May as evidence of clinical involvement by Dr Safdar, but in the event the PLDP considered all of the medication had been issued together. They found a variety of clinical judgments would have been required across the dates, other than in relation to the reauthorisation of lansoprazole on 5 May which was noted to be a repeat prescription capable of completion by administrative staff. They found that the Symbicort issued on 10 January 2020 would have required a clinical judgment, however, and that given the closeness in time of the reauthorisation of the methotrexate and lansoprazole, this must necessarily have also demonstrated clinical input by the same person. Dr Sharma's view was that clinical input and due diligence would have been required for the reauthorisation of methotrexate or co-dydramol.

105. Case 7 is the first in this sequence to deal with events on 10 January 2020. This was the first full day of Dr Safdar's suspension, and the day on which it is accepted he informed many of the staff in the practice in the morning that he had been suspended. We have set out in the appendix to this decision the sequential activity on the Appellant's account for 10 January 2020 so far as we are able to ascertain it from the material before us. It is of note that there are two logins (which overlap) for most of this day but only from the same machine. They exist consistently between 11.23 and 18.25 and are from one device. Very large numbers of patient records are apparently viewed by the account, in distinct batches. The second, and relevant, starts at 17.08. By the time case 7's records are viewed, at 17.49 the account has already viewed 42 other patient records and, as we note in the appendix, issued medication in at least some of those other cases too. The login for the day concludes with the issuing of the 'to whom it may concern' letter in case 11 (no longer relied on) and there is a Change Task Owner to receptionist KB (unexplained) just prior to logout.

106. Given that this concerns login that afternoon from only one machine, we do not consider on the balance of probabilities it can be the Appellant. If he had completed the work from home at some point there would be a second login. If he had done it all in the practice he would have been there for a substantial period of the day. If he was simultaneously accessing the records from the same machine as others he would have been seen. And this is all in the context that this is the very day that he has first been suspended. The Respondent is asking us to conclude, essentially that Dr Safdar's response to being suspended was to return to the office, or to a login, and proceed to deal

with issuing medication to multiple patients the very next day, as well as logging the court letter for patient 11 which he had authorised the day before. We do not consider this credible. We are not content to accept that the Appellant had clinical input into issuing or re-issuing of medication on that day to patient 7

107. In relation to the 5 May we note that it is evident from C100 that although lansoprazole capsules were issued by Dr Safdar's account at 16.18, a CTO to Dr Hirani at 12.46 the same day made reference to the issuing of the exact same medication. In our view, therefore there was a very clear likelihood that the authoriser of the lansoprazole on that day was Dr Hirani, not Dr Safdar and that the later issue of the medication was a likely administrative 'sweep up'. We note that Dr Safdar's account accessed apparently 34 separate patient records between 16.17 and 16.25 that afternoon, in the midst of which lay case 7. Patient 502123 was given sumatriptan and promazine tablets; patient 101 also received medication at 16.20 which had been the subject of an apparent medication review: but the medication review had been noted at that lunchtime (12.45) to have been nudged by the POD, and was transferred at that point to Dr Hirani.

108. We accept that the issuing of the co-dydramol on 14 April remains unexplained and does appear to contain clinical judgment.

Case 8

109. This case concerned the giving of advice, reviewing and issuing medication and printed prescriptions on 6 April, 9 April and 5 May 2020. The PLDP found clinical judgment had necessarily been applied on 6 April in relation to an acute prescription for clobetasone, and in the medication reviews. The panel noted that the repeat prescriptions were largely administrative, but as they occurred so close in time to the issue of the clobetasone they would necessarily have been completed by the same clinician. Dr Safdar's response was that he was self-isolating at home with Covid-19 at this point and would not have been able to undertake the clinical activity alleged; the panel did not accept this particularly given the possibility of remote access. Dr Sharma agreed that the issuing of the clobetasone required clinical input.

110. In relation to 6 April, the C100 spreadsheet shows that the medication review was the subject of a change task owner to Dr Jivanjee at 11.58, but was then also recorded as having been undertaken by Dr Safdar 1 hour later at the same time as the clobetasone was issued. The other repeat prescription medication was the subject of a change task owner to Dr Hirani, at 11.59 and was re-issued in Dr Safdar's name at just after 1pm. We note again the evidence from C100 to the effect that the account logged in at 12.24 on that day, accessed some 23 patient records by 12.55, 10 of them all timed at 12.54. By 1pm the account had accessed 48 patient records. Patient 7100 was issued with semaglutide also at 13.01, approximately 10 seconds before the clobetasone was authorised.

111. Without further access to either the patient appointments records, more detailed examination of this patient's records, or the activity of Drs Hirani and

Jivanjee themselves on this day it is not possible to be certain of the chain of events, and whether the medication review involved the patient. But it seems to us that there is sufficient evidence to suggest on the balance of probability that these activities were passed initially to other clinicians, even if the decisions were subsequently recorded in the name of Dr Safdar. We also note that this accords with the pattern seen elsewhere in the records, and we note that given our conclusion that the Appellant was *not* likely to have had remote access to EMIS, it is difficult to see how he could have been involved in this activity if he was self-isolating at home with Covid. We could find no details of activity with respect to this patient on 9 April in C100.

112. On 5 May the issuing of duaklir, tamsulosin, and tiotripium bromide were all the subject of a change task owner to Dr Hirani at lunchtime that day before the medication was reauthorised at 16.18 (as part of a substantial batch). As we have noted elsewhere in relation to case 7, this reissuing again lay within the midst of a very substantial number of other patients. We again conclude that on a balance of probability any clinical input into this patient's case was passed to Dr Hirani and the outcome recorded in Dr Safdar's name as part of a sweep up after 4pm. We do not accept that this case demonstrates clinical activity by the Appellant whilst suspended.

Case 9

113. The Respondent relied heavily on this case primarily because of apparent contact made between the doctor and New Cross Hospital on that day to query why betablockers were missing from the patient's discharge summary following a serious operation in the previous days. Dr Sharma said that safe reconciliation of medication following discharge from hospital required a high level of clinical input and that the note on the system was more indicative of a doctor than a pharmacist. Such work was normally completed by a GP. The Appellant's case was that he would be 'absolutely mad' to speak to the hospital and then put it into the patient's records, knowing that he was suspended but also that the time taken and logistics of getting through to a hospital made it unlikely that a GP would do this. He contended that this was a 'deliberate' addition to the records by an unknown person intending to create the impression of clinical work by him. He strongly denied the accusation. He noted that no one had made any attempt to contact the hospital or to talk to the nurse to see what the records, or a potential witness, could add. We agree that this would have been an appropriate course for the Respondent to take, given the consequences for the Appellant and the weight now put on that alleged activity.

114. It seems to us that the idea that this was a deliberate action by someone intending to 'frame' the Appellant is intrinsically unlikely- this was clearly a genuine conversation about the patient with the hospital following discharge. The question for us is whether it has been established that the person having the conversation was Dr Safdar. The Appellant's own response to the allegation suggests that there is, in fact a discharge summary available for this patient and the contents have been added to the repeat prescription list. We did not have sight of any such document. However, we do not accept that the conversation that occurred with the hospital necessarily would have been

made by a clinician. Whilst the nature of the question put involved clinical judgment, the question itself, the call and the note on the system could all be administrative. Any clinician could have asked the administrative staff to make a call and obtain an answer. With respect to Dr Sharma we were not convinced by his explanation as to why this might not be a pharmacist (or an administrator who had spoken to a pharmacist).

115. There was only 1 login on 17 April, at 14.14 using the smartcard, and from MAC ending BA38. It is likely therefore that only 1 person was responsible for all activity that afternoon. The account logged out at 16.02. Between 14.19 and 3pm the account viewed some 30 patient records, including that of case 2 (for whom it reauthorises lymecycline and files a report) and accesses case 9 at 3pm. Most notably in our view is the change task owner action on this patient at 14.25 adding one of the receptionists, EC, who apparently moves some task on the system from active to complete, as it happens only seconds later. We do not have the records to establish what tasks were undertaken with the other patient records accessed that afternoon other than for patient 2649- for whom Tee2 testing strips were issued at 14.27.

116. In our view the fact that the conversation with the hospital came during a login session in which approximately 30 other patient records were accessed, and in relation to which at least one task was moved from the GP to an administrator, and then closed as completed suggests strongly that all of the activity here is being undertaken by administrative staff. We agree with Dr Safdar that even if he were unable to 'let go' from his practice, it would be inherently unlikely that he would expose himself so clearly in the records. Much more likely, in our view, is that an administrator acting under instructions from someone, and using the Appellant's login, would do so inadvertently. We do not accept on the balance of probability that this is evidence of clinical work by the Appellant or that those instructions necessarily came from him.

Case 12

117. This case concerned the alleged review and filing of blood results on 29 April 2020 and the conclusion that results required no further action, and to contact the patient. Dr Sharma agreed with the panel's conclusion that this was clinical activity of such range and diversity that it could only be attributed to the Appellant. The Appellant in his written response tacitly agreed that the work undertaken was apparently clinical but denied that it was undertaken by him.

118. We note that that the only record we have of the note itself lies in appendix 8 (B243) (and requoted at C187). The record on EMIS is made on 1 May, not 29 April, though the reason for that disconnect is nowhere explored. Dr Safdar's response focuses on 29 April, not 1 May when the access to the patient records occurred (there was no access to the patient record by Dr Safdar's account on 29 April). The note quoted by Dr Ahmad there indicates that the tests were ordered by Dr Jivanjee on 29 April but we have little evidence before us of the context in which that occurred. Appendix 8 notes that 'Dr TS' has viewed and commented on the results, but it is unclear whether that is simply an assertion by Dr Ahmad. We have not seen the specific entries, and

the bare record filing in C100 only indicates that the reports have been filed as completed that day. What is notable, however, is that there are a number of actions moving an 'unfiled' report to a 'filed' report, there is a change task owner to Dr Jivanjee of an unspecified sort in the midst, and then the 'filed' reports are marked as 'archived' reports 5 minutes later. More reports are filed and archived on 4 May, and there is a change task owner to Dr Jivanjee again on 5 May.

119. On the balance of probabilities, we are unpersuaded that this is evidence of clinical activity by the Appellant. The reports were ordered by Dr Jivanjee, as the Respondent accepts. Dr Jivanjee was clear with the Respondent that he had never seen evidence of clinical activity by the Appellant after his suspension. Given that a number of tasks have been assigned to Dr Jivanjee from the Appellant's account in the days following it is reasonable to assume both that any tasks of actual reviewing were undertaken by Dr Jivanjee, but also that it would be most surprising if, having ordered tests which Dr Sharma accepted were diverse and wide-ranging on a patient, Dr Jivanjee would not notice barely a few days later that the tests he commissioned had been reviewed and actioned by the suspended GP. We consider it possible that he might have though this had been done by the admin team using Dr Safdar's login, but (assuming he knew this) it would still, in our view, have caused him to ask questions. And of course Dr Jivanjee denied being aware that the staff were using the Appellant's login. Dr Ahmad's comments were made at a time when all and every action taken within Dr Safdar's account was attributed to him personally. On the evidence put before us it is highly questionable. We do not agree that this is evidence of clinical activity whilst suspended. The Respondent has not discharged the burden of proof.

Case 14

120. This concerned the issuing of medication on 10 April in the form of a number of repeat prescriptions and the commencement of a course of Colpermin, only the last of which was relied on as evidence of clinical activity. However, because of the proximity of the issuing of the Colpermin to the issuing of the repeat prescriptions, it was also considered by PLDP that they must necessarily have been authorised by the Appellant too.

121. For reasons given elsewhere in relation to other patients and having regard to the activity in relation to a range of patients on 10 April recorded in the appendix to this decision, we do not accept that the activity to authorise Colpermin provides evidence of clinical activity by the Appellant on the balance of probabilities. It comes firmly within a long list of other patient activity in a short space of time and is part of two distinct actions 2 minutes apart in EMIS the first of which logs the medication review and an administrative note (not seen by the Tribunal), before re-issuing some medication and the Colpermin, and a re-issuing of repeat prescription medication 2 minutes later. But between the two actions, as shown in the appendix comes a range of action in respect of other patients. There is only 1 login. Either this is all the Appellant or none of it is.

Case 15

122. This case concerned a medication review and the reissuing of Ventolin and tiotripium bromide inhalation powder capsules on 15 and 16 April 2020. Dr Sharma commented that the review and reissuing of an inhaler was something that was not an administrative task. The Appellant's response was that this was the day of the CQC inspection and that medication reviews are rarely carried out in isolation by a GP because it was not a good use of time. He noted that there was no wider review or interaction with the patient. Again, we note that accessing the practice appointments system might well have revealed whether and with whom the patient had engaged in this review.

123. The record of the medication review occurred at 14.45. Login on 15 April was at 14.05 and the first patient record was accessed at 14.15. Another login occurred at 14.29 but was from the same machine. The account accessed 12 other patient records before case 15 at 14.45. It then accessed another 21 patient records before 14.50 when this series ends. Only one other patient record was visible to us from this period and this indicates that patient 501152 was prescribed sertraline tablets at 14.46. For reasons previously given we do not accept that this is evidence of clinical input by Dr Safdar. It forms part of another chain of extensive patient review and prescribing which is unexplained.

Case 17

124. Case 17 concerned again the issue of medication on 10 January, 6 and 21 April 2020 and a medication review on 6 April. It was said that these were clearly clinical activity. Dr Sharma agreed. However, we note that this case is of a pattern with others. On 10 January the issuing of the sharpsafe container was contained amongst a range of others with the appearance of administrative action. We have already dealt with our view on 10 January and we consider the same analysis applies.

125. In relation to the 6 April, there is reference at 11.58 to a change task owner to Dr Jivanjee and reference is made to all of the medication which is then included in a medication review and issued at 12.57 the same day. The activity on this patient record bears an uncanny similarity to that on case 8, where case tasks are passed to Dr Jivanjee at 11.58 and drugs are issued around 1pm that day from the Appellant's account. Again, we do not accept that this demonstrates clinical activity by the Appellant on the balance of probabilities. In relation to 21 April 2020 it does appear that medication has been issued and we are unaware of the wider circumstances surrounding this. We deal with this below.

Case 18

126. This case concerned the reauthorisation of lymecycline capsules and the issuing on 14 April of the anti-psychotic olanzapine following request on 13 April as well as Zapain. Again, the PLDP concluded that this issuance of medication involved the exercise of clinical judgment and Dr Sharma agreed. The Appellant indicated his view that this would ordinarily be dealt with by one of the pharmacists or the POD. As before, we note that the request from the POD for authorisation of the 3 medications in question was apparently received on 23 January at which point it was the subject of a change task

owner to Dr Hirani. A subsequent change task owner citing the same 3 medications was dealt with at 8.08 on 14 February and transferred, apparently to Dr Jivanjee. It is unclear in what circumstances the medication was re-issued on 14 April and C100 and C115 do not provide any additional information. We note again that the patient was again the subject of a change task owner on 13 May to Dr Jinvajee, who might be expected to have noticed at that point that medication had been reissued by a suspended doctor if this was the case; we also note that no records have been obtained from the practice showing when, whether and how the patient in this case was seen by clinical staff in the practice.

127. Lastly, we note that at the time the patient's record is accessed on 14 April, at 16.16, it is the 7th record of 98 that are accessed before 16.43 that afternoon. It is unclear to us from that record what is going on in relation to the Appellant's account, but this would suggest that more than 3 records *per minute* were being accessed that afternoon from the Appellant's account. It does not suggest to us the application of any form of clinical judgment in the less than 1 minute that was taken to access and deal with case 18's medication on that date. Either the data presented to us here is corrupted, or there is some form of electronic activity happening or there is a very large amount of administrative activity possibly by more than 1 person. All logins on the day were from the MAC ending BA38.

Case 19

128. This case concerned the issuing of hylo-forte eye drops, dexamethasone drops and lorazepam on 10 January 2020. For reasons previously given we are not satisfied that the issuing of medication on the afternoon of 10 January involved the application of any clinical judgment by the Appellant in the context.

Case 20

129. The last case concerned medication reissuing on 14 April 2020 and, on 1 May and the commencement on 4 May 2020 of ferrous fumarate, folic acid, risedronate sodium and desunin tablets. Perhaps most importantly was a message left on the system by the administrator, LW, which appeared to ask the Appellant a question and to which there had apparently been a reply suggesting clinical involvement, as well as a conversation with the patient's daughter to which it was said that the Appellant had replied on 5 May. The PLDP accepted that the issue of medication on 14 April was a repeat prescription, but it found clinical activity by the Appellant on 1, 4 and 5 of May. Dr Sharma agreed with the PLDP.

130. The timing of the issuing of the medication on 14 April 2020 sits at 16.32 in the middle of the period of intense activity on the account referred to in the context of case 18 above. The RAW data suggests that the records of case 20 is accessed for less than 1 minute. Having regard to the data set out in the appendix below relating to 4 May we agree with the PDLP and do not accept that this demonstrates the exercise of clinical judgment by the Appellant. But we also note that this repeat prescription comes within the context of a significant range of other prescriptions being issued, in a manner very similar

to those on other dates on which reliance is still placed.

131. We also note that the context of a message being placed onto this patient's record by LW on the afternoon of 4 May 2020 *may* indicate her to be the author of all other activity on this account between 14.22 and 15.48 on 4 May given that there is only 1 login from 1 machine that afternoon. It is unclear however in what circumstances the response was made. The records of case 20 are not accessed by the Appellant's account again after 4 May until 14 May at 15.05 when the next entry on EMIS is recorded. It is unclear to us however what the context, timing or format of the response was if it is not marked in the EMIS extract we have. We consider therefore that it is outstanding, and not explained by the data before us.

Overall conclusion on the cases

132. In our view, question marks as to the origin and circumstances of clinical input do remain in relation to cases 2, 7, 17 and possibly 20.

133. But overall and given the considerable question marks which arise in relation to much of the evidence now relied on, we do not think we can have confidence in the cogency and accuracy of the evidence put before us, even in relation to those few remaining matters where there are question marks about how medication came to be issued or results filed. No one has suggested Dr Safdar saw patients himself; no one suggested he was giving covert advice to the staff, who were doing it for him. The allegation was that he was accessing the system, at the practice or from a remote location, and working on patient activity.

134. The nature of the activity recorded on the EMIS system has been overlooked because of too narrow a focus on patients' situations in the abstract. And it does not make sense: in case 1 he is said to have issued anti-depressant medication to the patient without any discussion or sight of the patient. And none of the locums have been asked to comment on the specific patients even though in some cases they were issuing repeat prescriptions themselves subsequently of medication apparently initiated by Dr Safdar at a time when suspended from practice, without this seemingly having been a cause for concern for them. They did not raise with the NHS any suggestion that they had seen Dr Safdar inappropriately interacting with patient records or prescribing medication. But we do not know because the NHS did not put this information before us.

135. We accept that it is not necessary to find a motive for action taken by the Appellant; but the case law is clear that more unlikely things require greater cogency in the evidence to establish them. The Respondent invites us to find that the Appellant undertook very specific clinical activity which it has now, effectively, cherry-picked from amongst the 99 first relied upon before the PLDP and down from the many hundreds of apparent clinical steps taken which were first assumed to have been his back in May 2020. But the consistency of these allegations now has not, apparently, been reviewed; and actions which the PLDP found could have been administrative and which the Respondent therefore no longer relies on sit cheek-by-jowl in time and login

with actions which are still maintained to be clinical.

136. As we noted earlier, it is possible, of course, that the answer to that is that these are *all* the actions of the Appellant himself; but the Respondent did not invite us to reach that conclusion, nor was any of this context explained to us. It is unclear if the parties have even considered it. And the pattern of behaviour that would necessitate on the part of Dr Safdar makes no sense. This is clearest in relation to 10 January 2020 where the logic of accepting that cases 7, 17 and 19 were proved would require us to also find that the Appellant returned to the practice on the morning after he was suspended, informed the staff, and then continued to work. But it is true on the other dates for which we have substantial information too.

137. The wider pattern of behaviour, as we have noted consists of large volumes of patient records being accessed in a very small space of time; in relation to those cases where we have sufficient data, medication is prescribed or results are dealt with; there is little or no commentary on the system, and tasks are marked as completed. As was first revealed in front of the PLDP, 47% of the activity in the account was transferred to other clinicians; we do not have confidence in the due diligence taken in relation to the rest.

138. The Appellant's own view was that the activity on the account was undertaken, at least in the relevant period, by a malicious unknown actor. In our view that is unlikely, and in any event the evidence as we analyse it suggests something more mundane, but also more concerning: wholesale access to the Appellant's account in bursts of activity unconnected to patient contact but with significant amounts of activity being undertaken in a very short space of time, some administrative, some apparently recording in very short order of no more than a minute or two, apparently clinical judgements or activity which has taken place at an unknown time and place. The approach of the Respondent, and the PLDP was to ask simply who else could it have been? But in our view, and with respect to the PLDP, we consider that to be an analysis that works only in the abstract of each case. The overall *pattern* of activity makes it unclear when any clinical judgment was applied and therefore by whom. We have evidence that some potentially clinical activity was being undertaken by Dr Jivanjee but recorded as being by Dr Safdar by the practice in the issuing of repeat prescriptions. There is at least a suggestion that some other of the patients in cases 1-21 were also in receipt of clinical advice or judgments elsewhere but the record keeping was occurring in Dr Safdar's name. And allied to this is our finding that the Appellant did not have remote access- meaning that he would have had to be present in the surgery for substantial periods of time for this work to be his. The evidence does not support that Dr Safdar was very regular in his attendance, certainly in the first few months after his suspension.

139. Ultimately, it is not necessary for us to finally resolve these issues. We have only to answer the question of whether or not on the balance of probability the activity was the Appellants'. We do not consider that the evidence is sufficient conclusive or cogent to that end.

140. In light of the above, we do not accept that the Respondent has discharged the burden of proof that the Appellant undertook clinical work whilst suspended from the medical performers' list or whilst suspended by the GMC. Allegations 1 and 2 therefore fail.

Allegation 3: Failure to notify NHS England of an additional investigation by the GMC in October 2020

141. Allegation 3 was to the effect that the Appellant had been notified by the GMC by letter dated 21 October 2020 that it was investigating additional concerns raised about the activities of the Appellant relating to a member of the family being on the payroll but not working at the practice, and the staff being told to tell CQC that this person was on sick leave; that the Appellant was under an obligation to inform the Respondent of this under regulation 9 of the 2013 Regulations; and had not done so.

142. This was put to the Appellant in a letter dated 17 March 2021 after the Respondent had been notified directly by the GMC of the concerns, and the response from his solicitors said that he thought that the new allegations would be amalgamated with the existing ones and did not require separate notification. The solicitors said that there was no intention to conceal the facts. Before us the allegation was accepted and Mr Haycroft said that the issue had slipped through the net, the Appellant having been represented at the relevant time. The submissions made to the PLDP indicated that an apology had been made and the situation rectified.

143. On the material before us, we accept the concession made by the Appellant and find that he did fail to notify the Respondent of an additional investigation under regulation 9. However, we also accept the explanation given that this was a genuine error based on the assumption that it would not need to be separately notified to the Respondent.

Allegation 4: whether the Appellant has shown disregard for professional regulation

144. As we have not found allegations 1, 2 or 5 proved, the strength of allegation 4 rests entirely on the failure to notify the Respondent of the additional investigation. We have accepted the Appellant's explanation in relation to that, that his failure to notify the Respondent in October 2020 was a genuine error based on a misunderstanding of the requirements of regulation 9. We do not therefore find on the balance of probabilities that he has shown 'disregard' for professional regulation. Accordingly, this allegation is not proved on the balance of probabilities.

Allegation 5: Whether the Appellant left his smartcard in an unlocked room together with the passcode for it, which allowed unrestricted access to patient records.

145. This allegation (or finding as the Appellant preferred to call it) rested on the evidence of the administrative staff, including the practice manager and at least one of the administrators that they had had access throughout the relevant period of the Appellant's suspension to his smartcard, and his login credentials and that these had been kept in an unlocked draw and could be

accessed whenever needed. The allegation was denied by the Appellant.

146. During the course of the hearing before us it emerged in the Appellant's evidence (apparently for the first time) that in fact practice smartcards had always been kept in a safe in the reception office and that Dr Safdar had, he said, also left his there at the time of his suspension. The evidence from the CCG in August 2021, in response to Mr Couldrey's report had noted that the Appellant's practice was not set up to allow deputy access by members of the team to the accounts of others, and that the only means of accessing things in Dr Safdar's EMIS inbox and account (which would have included all test results for the practice) was either using the 'global' access login that the practice manager and others had which allowed sight of all inboxes, or via the Change task owner process which required the person to forward a task from their inbox *themselves* (see B611).

147. At the hearing, the practice manager Ms Walters freely accepted both that she had used her global access to access Dr Safdar's account directly herself and that she had changed his password and given it to other members of staff and used the smartcard. Dr Safdar himself said he was unaware of this until the allegations were made in August 2020 and he had put a stop to it thereafter. Ms Watkins in her interview with the Respondent had said that she did not know whether the Appellant had access to his smartcard at the practice.

148. On balance, we have concluded that the Appellant did not know that his smartcard was no longer in the safe after January 2020 nor that it was being used by the staff. We accept his evidence that he was stressed and embarrassed in January 2020 and did not discuss access to his system with the practice manager. We accept his assertion that he assumed that all tasks were being diverted to one or other of the locum doctors. The facts of this reflect poorly on the practice, and they strongly support the contemporaneous findings of the CQC inspection that information management at the practice was poor. This simply should not have happened. But the staff freely accepted it had, and the practice manager took responsibility for it. As a result, we conclude that Dr Safdar did not fail to protect his credentials, and that in fact he was let down by the systems and staff in the practice. We therefore do not find that allegation 5 has been proved.

Conclusion on suitability

149. We therefore find that the Respondent has not proved allegations 1 and 2. Allegation 4 was largely parasitic on allegations 1 and 2 and also must be dismissed. Allegation 3 was admitted, and we find that proved. Allegation 5, for the reasons we have given, we also find has not been proved on the balance of probability.

150. The Respondent accepted at the outset that it would not press for the Appellant's removal from the MPL on the basis only of allegations 3 and 5 being proved. As we have found only allegation 3 to have been proved, we accept the Respondent's concession. In the exercise of our discretion, we would not have been prepared to remove him from the list on that basis ourselves either. We have had specific regard to the criteria in regulation 15

and to the information received by the panel under regulation 9. We have also taken into account the fact that Dr Safdar remains subject to investigation by the GMC, and remains suspended pursuant to an Interim Suspension Order. We note that the GMC has not made any findings against him and has imposed no penalty. There is no live criminal investigation.

151. Having regard to all of those factors, we do not find that Dr Safdar is unsuitable to be included in the list for the purposes of regulation 14 of the 2013 Regulations. Accordingly, the appeal must succeed.

152. As a result of the Interim Suspension Order made by the GMC under s. 41A Medical Act 1983, the Appellant will remain suspended from the List pursuant to regulation 12(1A) of the 2013 Regulations until the outcome of the proceedings before the GMC.

Decision:

The appeal against the decision of the Performer's List Decision Panel of 2 December 2021 to remove Dr Safdar from the List is allowed.

Judge S. A. Trueman

First-tier Tribunal (Health, Education and Social Care Chamber)

Date Issued: 23 August 2022

APPENDIX 1

Patients are referred to by the case name they were given if relied on eg **(6)** or their EMIS number if not eg **502123**.

CTO- Change Task Owner.

What follows marks only the activity of which we are aware from the materials provided. It does not represent a complete picture of all activity on the account on any specific day.

1. **Activity on Dr Safdar's account on 10 January 2020.**

   Login 7.36- MAC ending BA38. Login 9.51- smartcard – MAC ending BA38. 1st logout, also 9.51.

   Login 11.23- smartcard- MAC ending BA38. (ie two separate logins now active)

   Between 17.08 – 18.25: views about 51 patient records.

   Accesses record **8426** authorises sertraline (17.10). Marks complete.
   Accesses record case **(19)** 17.10 - Authorises dexamethasone, lorazepam and hylo-forte (17.10) and cocodamol and diclofenac diethylammonium gel (17.12). Various tasks marked as complete.

   Accesses record case **(17)** 17.32 authorised sharpsafe disposal unity (17.32)

   Accesses record case **(7)** 17.49. - Authorises methotrexate (17.49), lansoprazole (17.49), Symbicort (17.50); CTO to named receptionist, LH, at 17.51 and marked complete.

   Accesses record case **(11)** adds 'to whom it may concern' letter re court attendance (18.24).
   CTO to named receptionist KB and task marked complete. Logout (18.25).

2. **Activity on Dr Safdar's account on 10 April 2020.**

   Login 14.04 smartcard- MAC ending BA38. Login AccuRx (14.06), Docman (14.07).

   Accesses records 5 patients including **502058** (14.10) Account logs a medication review, and an admin note (not seen). Reissues Atorvastatin and amlodipine as well as ramipril.
   Accesses case **(14)** (14.10). Issues colpermin, cinchocaine, hydrocortisone and buscopan. Marks tasks complete.

   Accesses another 14 patient records. Views **8426** (14.14). Issues Sertraline.
   Accesses **2649** issues empagliflozin tablets. (14.14).
   Accesses **5010** issues alverine tablets, Isphaghula husk granule powder. (14.14)
   Accesses **501551** authorises tiotropium bromide with inhaler and diltiazem capsules. (14.15)

   Accesses case **(14)** again and issues repeat prescriptions: sitagliptin, aspirin, desunin, amlodipine, solifenacin, lisinopril, lansoprazole, bisoprolol and atorvastatin. Marks complete. (14.15).
   Accesses another patient.

Accesses **223** issues flexipen medication (14.15).
Accesses another 5 patient records. Logout 14.56.

3. Activity on Dr Safdar's account on 30 April 2020.

Login 13.35. MAC ending 290. Accesses 3 patient records including **501386** where the pharmacy is called and a task passed to Dr Hirani by CTO. **501297** is also accessed. Logout 13.37

Login 14.22- smartcard MAC ending BA38. Login AccRx 14.24 and Docman.

Accesses 4 patients records including
Patient **5**: issues Otomise ear spray- acute prescription (14.29). task marked complete.

Accesses case **(1)** (14.29). Authorises mirtazapine. No comments.

14.29- 14.35. Accesses another 6 patient records.
14.35 Accesses case **(2).** Files test results.
14.37 Accesses case **(3).** Records the Vitamin D insufficiency and texts patient (also 14.37). This is the first access by Appellant's account to this patient since before 10 January 2020.

14.38 Accesses case (**4).** 14.39- CTO to Dr Jivanjee. Registers as new patient (new-born). Tasks marked as complete.
14.50 Patient allocated named GP.
14.50: comment added to file re vitamin K: "seems OK to me". [appendix 8 suggests this comment was made at 14.44]
Logout 15.04.

4. Activity on Dr Safdar's account on 4 May 2020.

Login 10.31 MAC ending 290. Accesses 2 records, including
2639 authorises sertraline tablets. CTO from TS to Dr Hirani. (10.32)
Logout 10.33

Login 14.22- smartcard MAC ending BA38. Login AccuRx 14.23. Docman (14.23)

14.26- 14.43 Accesses approx. 27 patient records (some appear duplicates)

Accesses **2561** (14.32) ibuprofen gel issued. CTO to Dr Hirani and removes pharmacy.

Accesses **patient 7937** (14.34). New task owner of Dr Hirani: notes 'collect at nominated pharmacy, new prescription of tramadol 50mg this is a new prescription doctor has prescribed for my knew as I cant have injection at present had for week all fine please order asap as have none left- Zapain tablets (14.34) (see 5/5 below).

Accesses **1811** CTO from Dr Hirani to Dr Jivanjee. Issues atorvastatin and lisinopril. (14.35) Task changed to complete [**note** this prescribing was relied on previously and shows an EPS Release 2 to Dr Safdar. The PLDP concluded it was administrative].

Accesses **502252** issues lansoprazole, lamotrigine, movelat gel, and ramipril (14.38) [**note** this was also previously relied on and considered by PLDP to be administrative]

Accesses case **(5)** (14.43) Files lab report on HBA1c and TSH blood results and marks task complete.
Case **(12)** files reports (14.43-14.44). Does not view record at same time.
Accesses case **(20)** (14.44). Issues AeroChamber with mask (14.47) and repeat prescriptions ferrous sulphate tablets, folic acid, risedronate, desunin. (14.51)
CTO to named administrator LW (14.52). Tasks marked complete.

Last patient recorded accessed 15.21.

Logout 15.48

5. Activity on Dr Safdar's account on 5 May 2020

Login 10.34 MAC ending 290. Accesses 3 patient records including patient **7937** see below.

Case **(8)** changes task owner to Dr Hirani re duaklir, memantine tablets and tamsulosin capsules (10.36).
Patient **502123** change task owner to Dr Hirani re promazine and sumatriptan tablets (10.36).

Logout 10.36

Login 12.20- smartcard MAC ending BA38. AccuRx login 12.20
Second login 12.21 smartcard MAC ending BA38. AccuRx login 12.21; Docman login 12.27
One logout 12.27.

Accesses approx. 33 patient records between 12.37- 13.00:
Accesses patient **6119** (12.37). Issues Ramipril (12.44). marks task complete.
Accesses patient **7937** (12.37). Edits record of Progynova, Furosemide and Zapain tablets (12.38). Adds tramadol (12.38). Marks complete. [see 4/5 above]

Accesses patient **2606** (12.43) Edits Ventolin evohaler. Adds medication review and admin note (12.43). Adds Seretide evohaler and Ventolin inhaler. Marks task complete.

Accesses Patient **101** (12.43)**.** Note from POD that medication review overdue: change task owner from POD pharmacist to Dr Hirani (12.45).

Case **(8)** change task owner from POD pharmacist to Dr Hirani – re acute tiotripium bromide capsules & inhaler (12.45)

Patient **7100** : Change task owner- to Dr Hirani from Dr Jivanjee- re semaglutide solution (12.46).
Case **(7)** Change task owner to Dr Hirani from Dr Jivanjee re lansoprazole capsules (12.46)

Case **(12)** creates new task and adds Dr Jivanjee as task owner. Immediately marks as complete (12.48). Files reports and archives (12.48- 12.49).

Accesses case **(6)** 13.00. Changes Bisoprolol tablet dosage & course duration (13.01); changes sodium bicarbonate dosage (13.02); adds repeat prescription alfacalcidol (13.02). Accesses record again (13.03).

Accesses case **(6)** 13.24. Adds new task owner, Mrs Lisa Smith (nurse). Acute prescription HBvaxPRO x 2 (13.26).

Case **(6)** adds new task for patient and changes task owner to receptionist EC (13.31). x2

14.49- Login MAC ending 290

2 records accessed (14.51) (unclear if from MAC 290 or BA38. Logical to assume MAC290.

14.52 logout

Case **(6)** changes task owner to Mrs Lisa Smith (16.17). Marks complete.

Patient **7100** issues drug semaglutide (16.17). Marks complete. [seems to be repeat prescription from 6 April]

Case **(7)** issues lansoprazole capsules (16.18). Marks complete.

Case **(8)** issues duaklir, memantine and tamsulosin capsules (16.18). marks complete.

Patient **502123** issued sumatriptan and promazine tablets (16.18)

Patient **101** – medication review added in name of Dr Safdar with admin note; drug issues added: acidex oral suspension peppermint; Bendroflumethiazide, amlodipine, lisinopril and lansoprazole tablets. (16.20). Marks task complete.

Case **(8)** issues tiotripium bromide capsules with inhaler (16.20).

16.25 logout.