**In the First-Tier Tribunal (Health, Education and Social Care)**
**Primary Health Lists**

**Heard at Manchester Civil Justice Centre on 4 and 5 November 2014**

**[2014] 2247.PHL**

**BEFORE**

**First-tier Tribunal Judge Melanie Plimmer**
**Dr Rajendra Rathi**
**Mrs Lorna Jacobs**

**BETWEEN**

**NHS ENGLAND**
**(GREATER MAMCHESTER AREA TEAM)**

**Applicant**

**v**

**DR WAYNE SEFTON DAVIS**

**Respondent**

The Applicant was represented by Mr S Butler (Counsel)
The Respondent was represented by Mr J Goldberg QC (Counsel)

## DECISION

1. The Applicant has applied for an extension of the Respondent's suspension from its medical performers list under the National Health Service (Performers Lists) (England) Regulations 2013 ('the 2013 Regulations'). This application is opposed by the Respondent ('Dr Davis').

**Restricted reporting order**

2. The Tribunal makes a restricted reporting order under Rule 14(1) of the Tribunal Procedure (First-Tier Tribunal) (Health, Education and Social Care Chamber) Rules 2008 ('the 2008 Rules'), prohibiting the disclosure or publication of any documents or matter likely to lead members of the public to identify the children or their parents in this case so as to protect their private lives.

**Summary of background to application to extend suspension**

3. Dr Davis is a General Practitioner ('GP'). He describes himself as a single-handed full time NHS General Practitioner. His practice is a large one of almost 3500 and is based in Salford. His patients are mostly but not exclusively members of the local Ultra-Orthodox Jewish community. He describes this as a "*very special and insulated community with its own laws, garb, rules and attitudes…*". We were told and it was not disputed that 30% of the practice constitutes 5-14 year olds, and that this is a particularly high proportion of children for a practice. Dr Davis has never faced disciplinary proceedings and is very well respected within the local community, having practiced as a GP there since 1991.

4. Dr Davis was originally suspended from the medical performers list under Regulation 12(1)(a) on 6 February 2014 following a hearing of the Performers List Decision Panel ('PLDP') on 5 February 2014. At the time the allegations were wide ranging but the evidence before the panel primarily related to safeguarding issues and inappropriate prescribing of medication to children with Attention Deficit and Hyperactive Disorder ('ADHD').

5. The Applicant appointed Ms Wild as the investigating officer and Dr Valentine as case manager after this. Unfortunately the Applicant was unable to complete its enquiries within six months and applied for an extension of the suspension on 6 August 2014 in order to enable it to do so. As Mr Butler has indicated, that investigation has now been completed and we have been provided with extensive documents and reports that have been produced as part of that investigation.

6. Importantly, the Applicant referred its allegations against Dr Davis to the General Medical Council ('GMC'). His case was referred to the interim orders panel by the GMC Case Examiner. This panel ('the GMC panel') considered the evidence in some detail during the course of a lengthy day and concluded that no order was necessary. The GMC panel specifically considered the two allegations that we must

consider relating to safeguarding / ER and prescribing medication to children with ADHD.

## Procedural history

7. On 17 August 2014 the Respondent served notice of his objection to the application for an extension of his suspension. The Tribunal issued directions, which both parties have complied with and the matter now comes before us.

## Hearing

Preliminary matters

8. At the beginning of the hearing the Applicant and Respondent sought permission to rely on additional documentation. These applications were unopposed and we considered both parties' additional documents, together with two bundles of detailed evidence containing relevant material from both parties. We also clarified that we had read and taken into account the parties respective skeleton arguments and the attachments that came with these.

9. Mr Goldberg QC made an application for the hearing to be heard in private in order to protect the Dr Davis's reputation. We note that rule 26 of the 2008 Rules provides that the hearing must be held in public subject to the remaining paragraphs within that rule. In order for the hearing or part of it to take place in private there should be good reasons for this. We were not satisfied that there were good reasons and we therefore declined the application. We were provided with extensive evidence that notwithstanding these proceedings Dr Davis continues to benefit from support within the community. We did not have sufficient evidence to suggest that his reputation would be particularly adversely affected by the hearing taking place in public. It is in the public interest that these hearings take place in public. The public are entitled to feel confident that these proceedings are transparent, fair and objective. In our judgment we were not provided with any good reasons for not having a public hearing.

10. Mr Butler clarified that the Applicant had now completed its investigations and that a full hearing could take place in December 2014. As the hearing proceeded it became clear that Mr Goldberg QC was not available in December 2014 and a hearing date before the PDLP was agreed for 2 February 2015, with a five day estimate. This hearing date was agreed to ensure that Dr Davis's representative of choice could attend but Mr Butler made it clear that if Dr Davis desired the hearing could have been fixed for an earlier date. Mr Butler also

acknowledged that whilst in the past the Applicant's concerns were more wide ranging, it now only relied on two issues: first, safeguarding concerns as they emerged in the patient ER, and; second, Dr Davis's approach to prescribing and treating children with ADHD.

Evidence

11. We heard evidence from Ms Wild, who was cross-examined by Mr Goldberg QC. Mr Goldberg QC indicated that he did not wish to cross-examine Dr Valentine and in those circumstances he was not called to give evidence. We then heard evidence from Dr Davis, who was cross-examined by Mr Butler.

Conditions

12. During the course of Dr Davis's evidence on the first day of the hearing we asked the representatives whether conditions had been considered as a pre-requisite to Dr Davis returning to the Performers List. Both representatives agreed that we did not have the power to impose conditions in these particular circumstances i.e. at a hearing considering an extension of suspension. Mr Butler indicated that there was the potential for a consent order but that a panel would have to be convened to determine this and it was simply impractical for this to be done now, although it could have been done if Dr Davis had proposed conditions or undertakings at an earlier stage. Mr Goldberg QC suggested that Dr Davis could give relevant undertakings and that these would be relevant to determine the necessity of any further suspension. Both representatives indicated they would take instructions overnight should the issue require further consideration by the Tribunal.

13. When the hearing resumed on the second day, Mr Goldberg QC requested permission to recall Dr Davis to give evidence. No mention was made of any possible undertaking at this stage. Mr Goldberg QC explained that he wished to recall Dr Davis in order for him to give evidence about the number of child patients at his practice. We indicated that there was no need to recall Dr Davis for this purpose because we were told and we accept that Dr Davis's practice includes a high percentage of children between 5-14 years (30%) and this is about three times higher than other practices in Salford. It was explained to us that this might be explained by the large families (quite often six children and not unusual to have ten) living within the catchment area of the practice. Mr Goldberg QC also invited us to consider a folder containing hundreds of pages of supporting letters from patients and members of the community. This bundle had not been filed in accordance with directions and was being submitted after

evidence had closed. We indicated that we already had considerable evidence to a similar effect within the bundles and that we were prepared to accept for the purposes of this hearing that Dr Davis has been and continues to be held in high regard by his patients and members of the community.

Submissions

14. Mr Butler helpfully provided us with a list of documents that are before us, but which were not before the GMC panel when it considered the matter in June 2014. He asked us to find that the Applicant had discharged the burden upon it to establish that suspension of Dr Davis is necessary because of significant unresolved concerns regarding his approach to safeguarding and children with ADHD.

15. Mr Goldberg QC reminded us that we must consider whether or not suspension is necessary in all the circumstances of this case. He submitted that suspension was not necessary: Dr Davis had learned from these proceedings and would not repeat any of the mistakes said to be attributed to him; he is regarded very highly within the community; if there were any mistakes in his approach to ER these were merely genuine mistakes and he acted at all times in good faith; there was no evidence that any patient had been harmed notwithstanding comprehensive reports about Dr Davis.

16. Mr Goldberg QC also submitted a proposed undertaking signed by Dr Davis regarding his approach to children with ADHD, if permitted to practice. This states that he will not prescribe to any patient under 18 any medication used in the treatment of ADHD or any anti-psychotic drug until the conclusion of his full PDSP hearing unless it is under the written direction and authority of a specialist of consultant status. Mr Goldberg QC submitted that this undertaking meant that a suspension could not be considered necessary.

17. At the end of the hearing we reserved our decision, which we now provide with reasons.

**Legal framework**

18. Dr Davis was suspended under Regulation 12(1) of the 2013 Regulations. This provides:

> "If the Board is satisfied that it is necessary to do so for the protection of patients or members of the public or that it is otherwise in the public interest, it may suspend a Practitioner from the performers list-

a) whilst the Board decides whether or not to exercise its powers to remove the Practitioner…or to impose conditions on the Practitioners inclusion in a performers list…"

19. The Tribunal's power to extend the period of suspension beyond six months, upon the Application of the Applicant, arises under Regulation 12(16). Regulation 12(17) states that if the Tribunal makes an order it must specify an end date or an event beyond which it is not to continue or that the period of suspension is to end on the earlier of a specified date or event.

20. The applicable legal framework was agreed by the representatives and we therefore only summarise that agreed approach, The Tribunal must adopt a cautious approach to determining the matter as it will be substantively determined by a panel appointed by the Applicant to hear the substantive matter. The Tribunal's role is to consider whether on the face of the evidence disclosed, there are matters which are sufficiently serious to necessitate suspension in accordance with regulation 12(1) of the 2013 Regulations, pending the substantive hearing. The burden of establishing that this test is met is on the Applicant, on the balance of probabilities.

21. We have taken into account the Department of Health Guidance and Advice for PCTs on suspension. Whilst this document is rather old, both representatives indicated that they knew of no other. This guidance makes it clear that suspension is a neutral act and not a disciplinary sanction and should be a rare event. Misuse of the suspension power can result in injustice, in damage to the doctor's reputation, career and personal life and in a waste of NHS resources.

22. Neither representative took the Tribunal to any authority to support the general approach the Tribunal should take to a case such as this or their respective specific submissions. Mr Goldberg QC however submitted that sections 41 and 41A of the Medical Act 1983 (which applies to decisions of the GMC) are worded similarly to the relevant 2013 Regulations and for this reason we should accord the GMC panel decision particular weight. He emphasised the importance of the detailed witness statement and appendices prepared by Dr Davis for that hearing. We confirm that we have carefully considered this evidence together with the decision of the GMC panel.

## Findings

Approach to the evidence generally

23. We make no findings of fact with regard to the two specific allegations against Dr Davis. We must however decide on the face of the evidence

available to us whether the concerns relied upon by the Applicant are sufficiently serious such as to necessitate suspension for the protection of patients or members of the public or that it is otherwise in the public interest.

24. Before we turn to these issues we wish to emphasise that on the evidence before us we have no reason to doubt that Dr Davis is held in high regard by his patients and the community he serves. We accept that he appears to be a hard-working GP who is committed to his patients and prepared to go the 'extra mile' for them. The continuation of the suspension will inevitably mean that Dr Davis will not be able to practice until the full PLDP hearing. The seriousness of the Applicant's concerns must be considered in this context.

Previous decisions of the PDLP and GMC

25. We have taken into account as a starting point, the findings reached by both the PDLP in February 2014 and the GMC's interim panel in June 2014. These reached opposite conclusions on the two issues before us and it was argued on behalf of each party that the decision that supported them should be taken into account. Mr Butler asked us to endorse the PLDP findings. Mr Goldberg QC urged us to find that the GMC panel reached clear findings on the evidence available to them including evidence from Dr Davis himself. We note that the GMC panel considered that it had substantial additional information before it. Mr Goldberg QC told us that the GMC panel consideration was a fuller one than that undertaken by the PDLP earlier.

26. We must consider the matter on the evidence available to us in November 2014 i.e. as at the date of hearing. We are not bound by either decision but should give the views expressed by those panels such weight as in the circumstances we think fit. We consider that the evidence available to us, which was not available to the previous two panels, is significant, detailed and cogent. This includes a number of reports including, in particular: a report on safeguarding concerns in relation to the records on ER undertaken by Ms Hartley dated 20 September 2014, a report by Mr Umesh Patel auditing the use of psychotropic medication in Dr Davis's patients under 18 years dated 20 October 2014, a letter dated 29 September 2014 with attachments from Dr Lloyd, a Consultant Child and Adolescent Psychiatrist. It is for this reason that whilst we have taken into account the previous decisions, and in particular the more recent decision of the GMC panel (because it had more information than the PDLP panel), we have made our own assessment of whether suspension is necessary on the information available to us.

The nature of the allegations

27. We accept, as did Mr Butler on behalf of the Applicant and Ms Wild when she gave evidence, that we do not have any evidence that any child has actually been harmed by the actions or omissions of Dr Davis. The Applicant however does not put its case on this basis. The Applicant submits that there is a risk of harm to patients because Dr Davis has (1) insufficient understanding of safeguarding issues as demonstrated in his approach to ER and (2) routinely and flagrantly breached guidance in his approach to patients under 18 with ADHD. On the face of the evidence available to us, we find that these concerns are sufficiently serious such as to necessitate suspension for the protection of patients or members of the public or that it is otherwise in the public interest. We now turn to each allegation.

Safeguarding / ER

28. The Applicant is concerned that Dr Davis has demonstrated little understanding of child protection and safeguarding procedures. The Applicant considers that Dr Davis should have taken a more robust approach once he recognised that ER was at risk of exploitation and that he should not have assumed that every claim made by ER against others was a fabrication such that a referral would be damaging to the family. These are very serious concerns notwithstanding the absence of any actual harm to ER. They are very serious because they call into question Dr Davis's willingness and / or ability to identify safeguarding concerns and make the appropriate referral thereby avoiding the risk of harm.

29. Dr Davis gave evidence before us for about half a day. He maintained that he had acted appropriately in not making a safeguarding referral in all the circumstances of the case and did not consider that the key safeguarding concerns identified by other professionals to be justified.

30. In her detailed report, Ms Hartley, a designated nurse for safeguarding children for NHS Salford Clinical Commissioning Group reviewed the Dr Davis's records regarding ER from a safeguarding perspective. She highlighted a number of safeguarding concerns including: medications prescribed to ER were not appropriately recorded and were increased or reduced in dosage without ER being seen, and were mainly based upon a history provided by her mother; records indicated that options other than prescribing medication were not sufficiently considered; safeguarding advice was not sought when it should have been. Mr Goldberg QC has asked us to attach little weight to this report on the basis that it was prepared by a nurse and not a doctor and further that it cannot be considered as objective. We do not agree

with these criticisms. We consider the report to be a balanced, detailed and comprehensive. We note that Ms Hartley is the designated nurse for safeguarding. She has carefully considered the records held in relation to ER and recorded her observations and reached conclusions in a balanced manner.

31. Dr Davis remains of the view that after he attended a meeting on 5 December 2013 to discuss the deterioration in ER's behaviour he was correct not to make a safeguarding referral in relation to ER. He has rejected Ms Hartley's clear view (as a nurse with particular experience of safeguarding) that after this meeting Dr Davis should have sought safeguarding advice or made a referral given his recorded concern as articulated in his letter to Professor Green the next day that ER "*is clearly at serious and urgent risk of physical and sexual exploitation*".

32. Dr Davis told us that by the time of the PDLP hearing (February 2014) the only possible indicator of any abuse on the part of ER's parents was an allegation that her father had pulled her off a sofa in the past. This is very difficult to reconcile with Dr Davis's recorded concern set out in the letter to Professor Green (December 2013), which states, inter alia:

> "…*when ER has any contact with officialdom, she immediately fabricates accusations of parental abuse with unpleasant sequelae*…"

33. Dr Davis was asked to clarify the above statement by the Tribunal chair but struggled to do so. He was asked to give an example of an accusation of parental abuse and indicated that the parents told him this happened in the past. His evidence to us was therefore of concern for two reasons. First, we were provided with inconsistent evidence of Dr Davis's own knowledge of ER's allegations against her parents. Second, Dr Davis seems to have accepted the parents' concerns at face value. This must be considered alongside Dr Davis's practice of increasing / decreasing / prescribing medication for children without seeing them and at the behest of their parents only (as documented in the case of ER in Ms Hartley's report).

34. Mr Goldberg QC has sought to persuade us that when considering the seriousness of the allegation we should bear in mind that any mistakes were genuine and that Dr Davis made his decisions in good faith. He reminded us that Dr Davis took a lead responsibility in convening an urgent meeting that included other professionals and he took the extraordinary step of seeking advice from Professor Green, a professional at the top of his field. It was submitted that there was therefore no evidence to contradict Dr Davis's assertion that he was

acting in good faith and was not attempting to avoid the relevant authorities. That might well be so but we still consider the allegation to be a serious one. The evidence before us does not indicate that Dr Davis has demonstrated insight into his failure to recognise that he should have made a safeguarding referral on this occasion. Dr Davis said that "*without a doubt*" he had learned lessons. These did not however include his approach to safeguarding. He focused almost entirely on his need to write more detailed records. Dr Davis told us that Professor Green did not suggest a safeguarding referral when he spoke to him or after he wrote his letter. We do not know the full details of that conversation. We do know that Professor Green did not take ER's referral but arranged for her to be seen by another psychiatrist. It is difficult to see how as Dr Davis asserted before us that he "*passed the buck*" to Professor Green regarding safeguarding.

35. It was submitted on Dr Davis's behalf that if he had made a safeguarding referral the full force of the weight of the state would have been brought down on the family and there was a risk that ER might be taken into care. Had Dr Davis clearly and fully acknowledged before us that he has made errors in judgment regarding safeguarding and that he would be more alert to making referrals in the future, then our assessment of the seriousness of the Applicant's current concerns regarding the risk to young patients might be different. We however found Dr Davis very reluctant to genuinely accept that ER should have been referred, or indeed that other patients in similar circumstances should be referred. We must consider the seriousness of the allegation in this light. The allegation might have been less serious at this juncture had Dr Davis shown insight into the possible consequences of his accepted failure to refer. We regard the allegation as remaining serious on the face of the evidence. In so finding, we bear in mind Dr Davis's evidence that he has made referrals to social services on three occasions. We agree that this prima facie suggests that Dr Davis may not be adverse to making referrals generally. However the allegation is that Dr Davis shows little understanding of safeguarding and has failed to take a robust approach in certain circumstances including where parents of the patient (as in the case of ER) do not wish him to for reasons relating to distrust of the authorities and fears of allegations against them. In our view this concern is sufficiently serious such as to necessitate suspension for the protection of vulnerable patients under 18 and it is otherwise in the public interest.

36. Although the GMC panel concluded that it did not have any information to support the suggestion that Dr Davis acted inappropriately in failing to make the safeguarding referral, this Tribunal has decided that it has the necessary information supportive of the Applicant's allegation.

This information may well be rebutted by Dr Davis or he may come to reflect further on his omissions in time. The information available to this panel is sufficiently cogent and serious to render suspension necessary, particularly when viewed together with the concerns regarding the treatment of children with ADHD.

ADHD / medication

37. The recent report of Umesh Patel clearly concludes that Dr Davis: has initiated prescribing of psychotropic medication in 64 children over a 12 month period, when the relevant guidance states that GP initiation of such medication should be the exception rather than routine practice; has not been formally trained or supervised in this area; diagnosis and monitoring has not been undertaken in line with NICE guidance, BNFC or the product license; clinical records for patients do not contain sufficient information on why medication which deviated from the license was prescribed; patients were rarely recorded to be involved in diagnosis, treatment or other options available.

38. Mr Goldberg QC submitted that whilst such findings might be very serious for a GP without specialist experience, they were not serious in the case of Dr Davis. This is because he has over 20 years experience in the field and obtained excellent results as evidenced by his own audit of patients. We regard the findings in Umesh Patel's report to be serious. We accept Dr Davis has taken a special interest in this area but in our view we have been provided with prima facie cogent evidence that he has patently breached important NICE guidance regarding not just prescribing but monitoring and other treatment options, without sufficiently justifying his approach within the records and without the benefit of formal training or any form of formal supervision. We have taken into account Professor Hill's letter dated 14 February 2014. This offers some support to Dr Davis's approach. We however note that there are a number of caveats provided by Professor Hill such as regular discussions with experienced clinicians, monitoring patients in accordance with NICE guidance, suitable involvement of children in prescribing and treatment. We have also taken into account page 55 of the NICE guidance on ADHD. This highlights that the guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the individual patient. The allegations against Dr Davis however are premised on his fundamental disagreement with much of the guidance and his failure to properly explain / justify / record why he has made treatment decisions inconsistent with the guidance.

39. Mr Goldberg QC stressed that there was no evidence that any child with ADHD has come to any harm and that unequivocal support for Dr

Davis's approach to individual children can be found in Dr Lloyd's factual breakdown of the patients that were referred to Salford CAMHS. Mr Goldberg QC submitted that this information supported Dr Davis's own audit (which concluded that he had a 100% successful treatment rate for children with ADHD). We however note that Dr Lloyd has worded her letter to Ms Wild carefully. She acknowledges that the Applicant is trying to establish whether any patients have come to harm but reminds Ms Wild that Salford CAMHS has not been commissioned to investigate or give expert opinion on Dr Davis's practice. Dr Lloyd simply provides factual information about some of Dr Davis's patients that have been referred. She has not reached any conclusions on Dr Davis's approach to treatment of children with ADHD. We bear in mind that there are a number of examples in which Dr Davis's diagnosis is shared by that of the CAMHS specialist and his prescriptions have been continued. We also note that there are a number of examples where medication has been substituted or added to (Cases 8, 9 and 10), different treatment options have been initiated such as other forms of non-medical intervention (for example psychological work as in case 2) and further assessment on diagnosis is ongoing (for example, cases 2, 10 and 12). Dr Davis made it clear to us that he considered medical intervention to be the most important one and that he considered that this alone would usually address the symptoms of ADHD. This is contrary to the NICE Guidance and the Summary of Product characteristics which according to Umush Patel (4.3.1.8.4) make strong and unequivocal recommendations with regard to drug treatment being a part of a comprehensive programme including psychological, educational and social measures. We note Ms Hartley's finding regarding ER that had Dr Davis considered options other than prescribing medication, ER's own needs and that of her family may have been more appropriately met at an earlier point.

40. Mr Goldberg QC anticipated that the Tribunal might regard the Umush Patel report as giving rise to serious concerns and in an effort to meet those concerns offered the solution of an undertaking as described above. It was argued that Dr Davis's undertaking not to prescribe medication for children with ADHD would entirely minimise the risk of any harm or Dr Davis breaching any guidance. The undertaking was offered at the end of the hearing and during the course of submissions. In our judgment it insufficiently addresses some of the significant underlying concerns or practical difficulties likely to arise. The undertaking only relates to the prescription of medication. It does not address other concerns such as: Dr Davis diagnosing ADHD without formal training or supervision; Dr Davis failing to give advice and recommend a range of possible treatment options; Dr Davis's lack of sufficient involvement of children in diagnosis and treatment. Dr Davis has strong views that are inconsistent with NICE guidance and the

undertaking will not prevent Dr Davis from discouraging patients (who hold him in high regard) considering other non-medication treatment options.

Proportionality

41. It is important that we consider the allegations together to determine whether the sanction of a further period of suspension is necessary and proportionate. We entirely accept that the allegations are not at the most serious end of the spectrum and do not involve any criminal wrongdoing or deliberate impropriety. However the allegations relate to Dr Davis's approach to safeguarding children and treating children. Dr Davis remains steadfast in his belief that he has done nothing wrong notwithstanding extensive and detailed reports to the contrary. On the face of information available to us, including the documentary evidence and Dr Davis's own evidence, we are satisfied that there is a serious risk of harm to patients, in particular children. We bear in mind that Dr Davis has been suspended for a lengthy period already and as Mr Goldberg QC submitted each day that he is suspended feels like an eternity to him, and has adverse consequences for himself, his family and his practice. We consider that the Applicant has acted reasonably in taking steps to investigate its concerns. Much of the relevant evidence is very detailed and it is understandable why it was only finalised in September and October 2014.

**Conclusion**

42. Having considered all the relevant circumstances, we are satisfied that the allegations made against Dr Davis considered together and notwithstanding his undertaking, render an extension of his suspension necessary until the full PLDP hearing.

**Decision**

43. The application to extend Dr Davis's suspension is granted.

44. In accordance with regulation 12(17) of the 2013 Regulations, Dr Davis is suspended until a decision of the full PDLP hearing, which has been listed to be heard between 2-6 February 2015.

**Judge Melanie Plimmer**
**Lead Judge Care Standards & Primary Health Lists**
**First-tier Tribunal (Health Education, Social Care)**
**Date Issued: 11 November 2014**