PHL/15432

FIRST TIER TRIBUNAL, PRIMARY HEALTH LISTS

1 December 2011

Ms Melanie Lewis, Tribunal Judge
Dr Sati Anyancyagam, Professional Member
Ms Jillian Alderwick, Member

BETWEEN:

NHS WEST KENT PRIMARY CARE TRUST

Applicant

AND

Dr RICHARD DUNN

Respondent

DECISION WITH REASONS

Representation

The PCT was represented by Mr Matthew Barnes, Counsel instructed Capsticks.

Dr Dunn was represented by Mr Brendan Finucane, QC leading Counsel instructed by Nabarros Solicitors.

The Application

1. West Kent Primary Care Trust ('the PCT') applied to the First-tier Tribunal (Primary Health List) on 10 October 2011 for an extension of the

period of suspension from the Performers' List imposed on Dr Dunn on 18 October 2010 for a further six months. Suspension was pending determination of whether Dr Dunn should be removed from the List, contingently or absolutely, on grounds of efficiency and unsuitability, pursuant to Regulation 13 (4) of the National Health Service (Performers' List) Regulations 2004 ['the Regulations']. That application was opposed by Dr Dunn's solicitors in a letter with enclosures dated 31 October 2011.

2. At a Telephone Case Management Directions hearing before Judge Hillier on 10 November 2011, a number of case management directions were made. A bundle of documents was lodged pursuant to directions, amounting to 2 lever arch files (not paginated but tabulated), Statement of Case and skeleton arguments. Mr Barnes served his skeleton argument only on the morning of the hearing. Mr Finucane QC objected but as Mr Barnes had only received the papers the night before, the content was not controversial and was likely to assist us, we allowed the document to be submitted.

Decision

3. The unanimous decision of the Tribunal is that the application for a further extension of the suspension should be refused. Dr Dunn has agreed to the Conditions for Contingent Removal paragraphs 1-10 signed by him and attached to this decision.

REASONS

The Relevant Law

4. Dr Dunn was suspended from the Performers List under Regulation 13 (1) (a) of the Regulations which provides:

"If a [PCT] is satisfied that it is necessary to do so *for the protection of members of the public* or is otherwise in the public interest, it may suspend a performer from its performers list in accordance with the provisions of this regulation –
…(a) while it decides whether or not to exercise its powers to remove him under regulation 10 or contingently remove him under regulation 12;"
[*emphasis added*]

5. The power to extend that suspension arises under Regulation 13 (4):

"The period of suspension under paragraph (1) (a) or (b) may extend beyond six months if –

(a) on the application of the [PCT], the FHSAA [now First-Tier Tribunal] so orders; or

(b) the [PCT] applied under sub-paragraph (a) before the expiry of the period of suspension, but the [First-Tier Tribunal] has not made an order by the time it expires, in which case it continues until the [First-Tier Tribunal] makes an order".

6. By Regulation 13 (5) if the [First-Tier Tribunal] does make an order under 13 (4), "it shall specify –

(a) the date on which the period of suspension is to end;

(b) an event beyond which it is not to continue; or
(c) both a date on which it is to end and an event beyond which it is not to continue, in which case it shall end on the earlier of that date or that event, as the case may be."

7. Department of Health Guidance and Advice for PCTs contains some guidance on suspension, set out within the bundle. While the guidance is directed principally to the exercise of the initial power to suspend by the PCT it is states among other things:

a. "18.1 suspension is a neutral act not a disciplinary sanction. It is intended to protect the interests of patients, staff and the doctor who is suspended. It should therefore 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 waste of NHS resources. Therefore it should only be imposed once the PCT has considered whether there is a case to be answered and whether it has reasonable and proper cause to suspend….." examples are then offered.

b. "18.4 suspensions should be no longer than is necessary".

c. 18.5 In respect of applications to the Tribunal for an extension: "the [First-tier Tribunal] will look for evidence that the PCT is taking all possible steps to conclude its inquiries…" and at 18.6: "This means that it is essential for PCTs to commit the resources to deal with the cause of the suspension, and to take substantive action [to remove him]… or to permit him to return to work without conditions, as quickly as possible."

8. The Tribunal's approach to facts which may form the basis for allegations which subsequently need to be determined by a Panel of the PCT or by a differently constituted First-tier Tribunal is a cautious one. This Tribunal does not make any finding of fact in respect of such allegations. We have merely considered whether, on the face of the evidence disclosed, there are matters which are sufficiently serious to necessitate suspension (applying the criteria in Regulation 13 (1) (a)) while further attempts are made to set up a substantive hearing to make findings about the alleged failures by Dr Dunn in his dealings with patients and some clinical matters relating to a failure to examine and prescribing. There are also issues relating to his record keeping and his failure to send in appraisals on time.

Background and Facts

9. Dr Dunn qualified in 1986. He was in partnership until April 1998 with another GP and they then split their practices, but continued to work from the same premises. Dr Dunn's practice was known as the Red Practice and the other GP's the Yellow. We clarified that the complaints which form the basis of the allegations came about because the PCT asked the patients requesting a transfer from the Red to the Yellow practice to fill out a form providing reasons. In effect it was an 'exit' investigation. The PCT became concerned that a significant number of the forms raised concerns about Dr Dunn's conduct towards patients, and the treatment he was providing.

10. On 19 August 2010, the PCT instructed Dr Alison Milroy to conduct an investigation. We did not have a copy or read her report, but it is clear that she raised a number of concerns about Dr Dunn's relationships with his patients, a failure to examine and his prescribing amongst other things.

11. There has been delay in this case for reasons we will set out. However by 18 October 2010, when Dr Dunn was suspended from the Performers' List, the core of the allegations was clear. This is not a case where the PCT ask for more time to make investigations.

12. Dr Dunn has had, until the events giving rise to this suspension, no adverse professional findings, made against him but there is a mention in the papers that the PCT had some concerns from about 2008.

13. The suspension arises from the information on the transfer requests and the report of Dr Milroy. As a result of Dr Milroy's investigation, a letter was sent by NHS West Kent to Dr Dunn on 7 March 2011, setting out the following seven allegations :

(i) Dr Dunn's lacks of professional inter –personal skills has resulted in the breakdown of the doctor patient relationship;
(ii) Dr Dunn has behaved in a grossly unprofessional and unacceptable manner towards patients;
(iii) Dr Dunn has failed to respect the skills and contributions of his colleagues;
(iv) Dr Dunn has failed to examine and provide treatment to patients when that was clinically appropriate;
(v) Dr Dunn has poor record keeping;
(vi) Dr Dunn has filed to comply with the duty of confidence owed to patents and
(vi) Dr Dunn has failed to complete his appraisals within the required timescales.

14. The thrust of the case against Dr Dunn is his conduct towards and his relationship with patients. We were directed to paragraph 20 to 22 of the GMC

Good Medical Practice which sets out expectations in respect of the 'doctor-patient partnership' and 'good communication'.

15. We didn't examine each allegation in detail but what were described as 'highlights' were set out in the NHS Statement of Case: paragraph 11. The witness statements were not in our bundle but certain themes emerged. A number of patients complained of no eye contact and/or a rude and abrupt manner. Patients complained of Dr Dunn being bullying and intimidating, when they felt too ill to defend themselves.

16. It was alleged that on occasions Dr Dunn had been in gross breach of the standards. Again, highlights were set out at paragraph 12 of the Statement of Case :A – K. These are more specific allegations and they are not just about Dr Dunn's manner but specific complaints, for example complaining that a patient MK had been 'dumped' on him. By way of another example set out in the highlights, he raised his voice to complain about the conduct of MK and his wife and 'raved' in disparaging terms about advice provided by another healthcare professional. Mr Finucane QC put it that Dr Dunn was concerned when his referrals had not been followed through properly and patients had simply been sent back to him.

17. There is also a specific example of Dr Dunn allegedly telling patient BM that he was an 'arsehole' and was going to die a 'horrible death' and was a 'burden to him'. In the bundle Dr Dunn set out specific responses to these allegations, which we were not asked to consider in close detail. In relation to that particular allegation which he does not accept, he says that whilst he may have used that word it was not a descriptor of the patient but a basic description of a part of his anatomy.

18. In relation to specific foul language another patient DET complained that Dr Dunn, without turning round had said 'Now get out of my office, you're pissing me off and no doubt you piss off other people off as well'.

19. We read other examples of where Dr Dunn hadn't simply given patients an explanation of the choices available to them if they continued to for example smoke, but allegedly told them that they would die a horrible death.

20. The third group of allegations relate to a failure to respect skills and contributions of colleagues and is set out at paragraph 15: A-C. Again we have not read the statement of Heather Smith an anti coagulant nurse but we were told by Mr Finucane QC that whilst she alleged that Dr Dunn had originally been aggressive, she did ultimately accept that he had calmed down.

21. The fourth set of allegations relates to a failure to provide treatment and care as clinically appropriate. Dr Dunn has set out a very detailed response to those allegations. It appears that an allegation relating to prescribing for the patient MK is not now being pursued. Mr Finucane QC put it that there can

often be two views as to correct prescribing and this case does not turn on a glaring omission or error.

22. The fifth set of allegations relate to poor record keeping. These relied upon Dr Milroy's investigations.

23. The sixth set of allegations relates to a failure to complete appraisals within the required timescales and didn't relate to just one year. In 2007/8 it was submitted they were 10 months late, for 2008/9 it was submitted they were nearly 2 and a half months late. On 16 July 2010 the PCT wrote to Dr Dunn reminding him of his obligation to complete an appraisal, which he did 8 months late. Mr Finucane QC put it that if late, the appraisals rated Dr Dunn's clinical abilities 'extremely highly'.

24. The delay in hearing this case clearly requires explanation given the core of the allegations was on the table by October 2010. Regulation 13 clearly envisages a short period of suspension. Both sides dealt in detail in their skeleton arguments as to why this case has taken so long to come to a full hearing, which we summarise to explain the delay

25. On 7 March 2011 the PCT wrote to Dr Dunn giving him details of the case against him which, as we have recorded, has not essentially changed. He was served with 16 statements and 14 sets of medical records and informed of the constitution of the Panel.

26. On 11 March 2011 Dr Dunn's solicitors objected to the date of the hearing on the basis that there was insufficient time to prepare. The Medical Defence Union (MDU) objected that Dr Dunn couldn't be expected to respond to nearly 3,000 pages of material 28 days before the hearing which was a breach of Dr Dunn's right to a fair trial under Article 6 of the Human Rights Act.

27. The second concern has been an ongoing one. It related to the composition of the Panel. Since September 2008 NHS West Kent's Decision Making group had discussed various issues relating to Dr Dunn, regarding actual or perceived problems relating to him or his Practice. These meetings were attended by four people who it was intended would sit on the Panel. They took part in the discussion.

28. It is not necessary for the purposes of this decision to set out the legal argument advanced by both parties in correspondence and summarised at the hearing because we do not have to decide the point of whether there would be bias or perception of bias if those who have participated or were professionally close to the decision or managers of the PCT sat on the Panel. The MDU argument was that the Dr Dunn's Article 6 ECHR rights would be infringed and that no man should be a judge in their own cause, which would be the case if certain decision makers or managers sat on the PCT panel. This of course is not novel to this case and affects many regulatory bodies, as discussed in The Queen (on the application of Darsho Kaur) v The Institute

of Legal executives Appeal Tribunal (2011) EWCA Civ 1168. The Court of Appeal upheld the principle that "no man can be a judge in his own cause".

29. Suffice to say that it was only when threatened with Judicial Review that the PCT agreed to form a different Panel. We were told that that was a pragmatic response to avoid further delay, rather than acceptance of the position put forward by those who represent Dr Dunn. That explains the delay from June to September 2011.

30. A hearing finally got underway on 7 September 2011. It was to be heard over 7 days. On 9 September 2011 both parties were informed by the Chair, a barrister instructed for the hearing, that a Panel member had shown his relative a confidential report produced for the hearing by Dr Dunn's expert psychiatrist. He had not only shown it but discussed it with the relative who had expressed an adverse opinion about the report and about the expert in question which the Panel member relayed to the other members of the Panel. The hearing had to be abandoned after three days.

31. The PCT now propose that the case is provisionally listed for 6, 10, 11, 12 and 13 January 2012 but Mr Finucane QC, Dr Dunn's preferred Counsel is not available on 6 January 2012. It was argued that the case will take in excess of 5 days as evidenced by the rate of progress in September 2011 when only 3 witnesses were heard over three days. They now further argue that no-one involved in the management of the PCT should sit on the Panel. Therefore the position before us is that no definite dates have been identified and the best estimate is that the case should be resolved between January to April 2012.

The Position of the Parties at the Hearing

32. Both parties attribute delay in the case to the other.

The PCT

33. It is the position of the PCT that the allegations were well evidenced, serious, ranged across the skills required of a GP and were of widespread impact.

34. Dr Dunn is a GP, so his de-skilling would not be as great as, for example, a specialist. Whilst he couldn't work it was reasonably expected the situation would be resolved early in 2012; he was suspended on full pay and he could spend the remaining months undertaking appropriate courses.

35. There was an issue of patient safety as, if the patients were too frightened to come to their doctor because of what had been described as an aggressive or bullying tactic, this could affect their willingness to see him.

36. Some time was spent discussing the conditions offered on behalf of Dr Dunn. In September 2011 the MDU wrote to NHS West Kent suggesting that

further delay and expense could be avoided if Dr Dunn could return to work subject to conditions. At a meeting on 4 October 2011, the PCT Decision Making Group considered whether it would accept contingent removal under these conditions but decided it would send the matter to a further hearing.

37. It was not correct that simply because the PCT were no longer pursuing an allegation in relation to the prescription of Warfarin for one patient MK that there were no clinical concerns.

38. Whilst there had been delay, the blame for this was laid squarely at the door of those who advised Dr Dunn.

Dr Dunn

39. We stated at the beginning of the hearing that even if Dr Dunn were disputing words that he was alleged to have spoken or behaved in a manner a number of patients objected to, that perception of his behaviour was all important. Mr Finucane QC accepted that point.

40. As the hearing developed, Mr Finucane QC emphasised that conditions had been offered on behalf of Dr Dunn because it seemed possible that it might be a way of resolving issues. Further it demonstrated that he was prepared to be reflective, whilst at the same time exercising his right to challenge the allegations, which his detailed notes showed that he would and could do.

41. The conditions signed by Dr Dunn at the hearing, were the ones set out in a letter from Nabarros dated 3 October 2011. The conditions at paragraph 10 also incorporated conditions set out in an earlier letter dated 14 September 2011. At our suggestion they were incorporated for clarity into one document. Mr Barnes made it clear that the PCT were not agreeing to conditions. The PCT intended to pursue a full removal in this case.

42. Mr Finucane QC argued that the public interest and patient safety would be appropriately reflected by Dr Dunn returning to work under what were stringent conditions. He emphasised that this was the 'last chance saloon' and that he would not be defending Dr Dunn if there were further patient complaints.

43. We have recorded in summary the reasons for the delay in this case. We refer to case law only to make clear the perimeters of the argument.

44. Mr Barnes stated that lengthy extensions are not unusual: see GMC –v- Kumar [2009] EWHC 1412 relating to an interim suspension by the IOS committee of the GMC of 18 months. Mr Finucane QC instead cited the recent decision of Blake J in Nursing and Midwifery Council –v- David Miller [2011] EWHC 2601 (Admin) there should not be protracted delay. He further relied on established principles of Silber J in Dr Cohen –v- GMC [2008] EWHC 581 (Admin) how far they are remediable.

Discussion:

45. The bulk of the allegations in this case were on the table in October 2010.

46. The bulk of the allegations relate to allegations (i) and (ii) relating to Dr Dunn's conduct towards and relationships with his patients and that on occasion Dr Dunn has behaved in a grossly unprofessional and unacceptable manner towards patients in breach of the standards set out in GMC Good Medical Practice.

47. Whilst we have not examined the full statements of the witnesses, the 'highlights' show some themes. A number of patients complain of Dr Dunn putting his back to them. That might be a question of how his computer was situated. A large number refer to a lack of eye contact and that Dr Dunn was bullying and hectoring. The third theme is that Dr Dunn was autocratic. He was the doctor and he knew best. This does not accord with current medical practice of working more collaboratively with patients, to give them choices and reflect on their own lifestyle.

48. Our task is not to make findings. We have to take a view about the evidence and we have to balance a number of factors.

49. A number of patients have made very specific allegations of language used to describe them. No doubt at the full hearing there will be extensive cross examination as to the context of the consultation in which words or behaviour was alleged to have been said and what exactly was or was not said. However, that they should have that understanding is troubling. It goes back to the point that it is the perception of the patient that is all important.

50. It has to be of concern given that witnesses' memories over time will fade. It will be the patients' account against that of Dr Dunn. The long delay and the need to restart the hearing are not likely to give the witnesses a confidence in the process.

51. Whilst troubling and over a period of time, the allegations did come about through a trawl made by the PCT to understand why patients were leaving Dr Dunn. We noted in only one case had the patient made a complaint to the practice manager at the time, which she said resulted in Dr Dunn calling her that evening and being abusive. Many such as patient MK had seen Dr Dunn over a long period on a number of consultations but the allegations appear to relate to one period.

52. As far as we are aware there are no specific complaints from hospital consultants and the like about Dr Dunn's conduct towards them. The only specific allegation from a professional we are aware of comes from Heather Smith the anti-coagulant nurse although even that was tempered in that she appeared to accept he eventually calmed down.

53. Overall our view is that whilst troubling, conduct and negative language to patients, are issues that are capable of being remedied.

54. The issue of care to patients being clinically appropriate was not developed before us in any depth. This will obviously have to be looked at in the context of Dr Dunn's overall case list. Broadly we accept Mr Finucane Qc's point that it is not a case of glaring error or omission. It too would appear to be a mater capable of being remedied.

55. We then examine the alleged failure of record keeping and appraisals, but these of themselves would not be likely to constitute the basis for removal without an opportunity for remedial action.

56. The PCT investigated and the case, which should have gone for a hearing shortly after October 2010.

57. This is not a case where it can be said that either party has 'sat on their hands'. We regard delay as a neutral factor. The delay has turned on legal argument and a glaring procedural irregularity when the case finally got under way.

58. We remain mindful of the issue of public safety but we are not satisfied that an extension of Dr Dunn's suspension is necessary for the protection of members of the public, nor is it otherwise in the public interest. The public interest will not be served by the continued suspension of an experienced GP.

59. We were told by Mr Finucane QC that no concerns were raised by the report prepared by the Psychiatrist independently instructed by Dr Dunn. Further he is prepared to see another Psychiatrist nominated by the PCT.

60. The thrust of the allegations relate to Dr Dunn's patient care skills and his manner. We bear in mind that concern raised by the allegations may well be better tested by a strict and intensive monitoring and supervision regime than through a lengthy cross examination at a formal hearing.

61. Dr Dunn is now in his mid fifties. He has worked as a sole practitioner for some yeas so will have his own way of doing things. Matters of personality and style may not be easily remediable. However, we weigh in Dr Dunn's favour that he is prepared to subject himself to stringent oversight by his colleagues. We are satisfied that Dr Dunn will be adequately supervised and monitored. Whilst not admitting his failures he is prepared to fund and work towards change.

Decision:

The unanimous decision of this Tribunal is that the application for an extension to the suspension is dismissed.

Appendix: A signed copy of the conditions that Dr Dunn is prepared to commit to.

Melanie Lewis
First Tier tribunal Judge

19.12.11