Case No. 15348

FIRST TIER TRIBUNAL, PRIMARY HEALTH LISTS

1 June 2011

Mr Duncan Pratt **Tribunal Judge**

Dr H Freeman **Professional Member**

Professor D Croisdale-Appleby **Member**

BETWEEN:

KENSINGTON & CHELSEA PRIMARY CARE TRUST

Applicant

-and-

DR MOHAMMED L RAHMAN [GMC No. 2659860]

Respondent

DECISION WITH REASONS

The application

1. Kensington & Chelsea Primary Care Trust ["the PCT"] applied to the First-tier Tribunal (Primary Health Lists) on 7 January 2011 for an extension of the period of suspension from the Performers List imposed on Dr Mohammed L Rahman on 12 July 2010 for a further 6 months until 12 July 2011, pursuant to Regulation 13 (4) of the National Health Service (Performers Lists) Regulations 2004 ["the Regulations"]. That application was opposed by Dr Rahman's solicitor's letter, with enclosures, dated 31 January 2011, and remains opposed.
2. At a telephone Case Management Directions hearing before Judge Burrow on 28 February 2011 the PCT asked for the matter to be set down for oral hearing on 1 – 3 June 2011 to accommodate its Counsel of choice. A number of further case management directions were made. A bundle of documents was lodged pursuant to directions, amounting to 523 pages, together with a further bundle (365 pages) of medical records for a patient about whose management a complaint had been made to the PCT. Opening statements and legal arguments were then submitted by both parties. On 26 May 2011 this Tribunal further directed that at the hearing, the PCT be in a position to inform the Tribunal: (1) what steps remained to be undertaken in order for the PCT to be in a position to decide whether to exercise its powers under Regulations 10 (to remove Dr Rahman from the Performers List) or 12 (to do so contingently) of the Regulations; (2) within what time such steps were reasonably expected to be complete, including whether completion may reasonably be expected before 12 July 2011; and (3) what measures (in summary) the PCT has taken, to date, to complete such steps.
3. At the oral hearing on 1 June 2011, the PCT was represented by Mr Michael Mylonas, of Counsel, instructed by Weightmans, solicitors, and Dr Rahman by Ms Mary O'Rourke QC, Leading Counsel, instructed by Nabarros, solicitors. Immediately prior to the hearing Mr

Mylonas lodged a "Response to issues raised by the Tribunal" dated and sent to Dr Rahman's representatives on the evening of 31 May 2011. All the documents were taken as read by the Tribunal (as was the case) at this hearing. In the event, when the parties appeared before us today, neither elected to call oral evidence, but both made submissions, which quite properly and helpfully focused on the main issues which this Tribunal had to determine, rather than the many consequential or satellite issues which had arisen between the parties since July 2010.

DECISION

4. The unanimous decision of the Tribunal is that this application shall be dismissed.

REASONS

The relevant law

5. Dr Rahman's 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*]

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".

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."

6. Department of Health Guidance and Advice for PCTs contains some guidance on suspension set out within the bundle at 1/E/2/4. 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."

7. 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 investigations are undertaken to determine whether the alleged failures by Dr Rahman in dealing with clinical correspondence and pathology results relating to one patient, are replicated in his practice generally.

Background and facts

8. Dr Rahman qualified MBBS in 1969 from Dhaka Medical College Hospital, and moved to the UK in 1973, practising in hospital medicine, before taking up a career in General Practice in 1981. He has been a sole practitioner since 1986, in North Kensington, and latterly from purpose-built premises within St Charles Hospital site, shared with two other sole practitioner GPs. Dr Rahman is a GMS contract holder. In January 2008 he was joined by a salaried full-time GP, whose sessions were considerably reduced after she had a baby in 2009, and locums have therefore been employed to supplement her sessions. In about 2007 the PCT awarded him a 20 years' service certificate. Dr Rahman's patient list is in the region of 3283 patients, but fluctuates: he practises in area where there is a relatively high turnover of residents and many do not have English as a first language.

9. Dr Rahman has had, until the events giving rise to this suspension, no adverse professional findings, nor indeed any complaints to the GMC or PCT of which those representing the PCT

were aware when asked by us. He is aged 64 and this is the first occasion on which his clinical competence has been questioned, so far as we are aware.

10. This suspension arises from a single complaint made on behalf of his long-term patient DJ by the patient's former wife. Much correspondence has been devoted to whether this complainant had locus to complain, whether the patient himself wished to complain or was incapacitated from doing so himself, whether there was jurisdiction to entertain the complaint at all, or whether it was considered as the complaints procedure required it should, among other issues. We are not concerned today with any of those issues. Nor are we concerned with issues of nursing and home care which take up some of the complaint.
11. The matter which has concerned the PCT arises from a report dated June 2010 which it commissioned from Nina Murphy Associates (NMA), to review the complaint concerning DJ. The NMA report identified some alleged failures of the management of some of DJ's blood results or clinical correspondence by Dr Rahman's practice, a concern about communication with the pharmacist over the supply of blister packs of pain-controlling medication to DJ, when that medication was being replaced by another, and the inadequacy of the in-house complaints process. Among other things, NMA recommended that the PCT "should conduct a further review of a much larger sample of records to determine whether the doctors at Exmoor surgery had failed to act on other abnormal results". The concern was that failures perceived by the NMA investigators might be replicated throughout the practice. Only the clinical matters were relied on by the PCT for the purpose of considering the need to suspend.
12. It is necessary to observe that (1) only two of the abnormal test results which were considered by NMA not to have been properly actioned were in fact ordered or received from the hospital by Dr Rahman personally (one of which was, on Dr Rahman's account, actioned but the patient declined to come in for a further blood test before he was again seen at hospital, but Dr Rahman did not make a contemporaneous record of this); (2) the NMA review was carried out "under the aegis of the complaints procedure adopting a lay as opposed to GP centric approach" [statement of Dr Kheraj B/6/281/para 5] and NMA was not involved in any disciplinary steps subsequently taken; and (3) the conclusions and criticisms of the NMA report are robustly contradicted by an expert report commissioned on behalf of Dr Rahman from Dr Jeremy Budd, with the one highly qualified exception.
13. We refer to the attached chronology which sets out other key events leading to the PCT's decision to suspend Dr Rahman on 8 July 2010. It was anticipated that a review of records for a larger cohort of patients would then be undertaken. On 30 July 2010 the Medical

Defence Union, on behalf of Dr Rahman, wrote to ask the PCT if they yet had a draft letter seeking patient consent to the disclosure of their records, as the writer suggested had been agreed. No such draft letter was provided, but on 15 October 2010 the PCT's Clinical Director sent a letter to all Dr Rahman's patients informing them that he had been suspended whilst the PCT undertook a review into a much larger sample of patient records, which was "necessary to assure itself of the overall care that is being provided to patients in the practice". It also offered them the opportunity to object to the use of their own records in that exercise but said "If we have not heard from you by 4 pm on that date, we will assume that you have no objection and agree to your records reviewed for the purposes of the stated review". This letter was not seen or approved by Dr Rahman before being sent and would have been the first notification from the PCT to his patients of a suspension which had taken effect 3 months earlier.

14. It appears from what we were told today that at different times (a) Dr Rahman's solicitors contended it was not reasonable to request disclosure of further patient records (because the request was based on the outcome of a flawed investigation [1/B/147]; and (b) there was an issue between the parties as to whether patient consent was required for the disclosure of their records for the larger review. Contention (a) is not argued on behalf of Dr Rahman today. Furthermore the PCT subsequently appears to have accepted that consent was required and that Dr Rahman was entitled to be reassured that the records he disclosed had patient consent for that to happen. At some point (prior to 29 January 2011 when solicitors for the PCT wrote to Dr Rahman's solicitors to inform them that they had oral consent from 29 patients) ticks were placed on a schedule, against the names of 29 patients who (the PCT contended) had contacted the PCT to consent to their records being used for the review. Since the senior PCT officer involved, and her personal assistant, have subsequently left the employment of the PCT, and have not subsequently been traced, no witness statements to substantiate that contention or to evidence what if anything was said to or by those patients, is available. By 13 April 2011 the PCT conceded it had not rely on the tick list to evidence consent and had no effective written or oral consent, so wrote to say it would prepare a letter for the approval of Dr Rahman's solicitors, to be sent to the 29 patients. No such letter was in the event submitted for approval.
15. One further complaint was subsequently received on 24 October 2010 from a Mrs P, on behalf of her husband, as a result of this exercise. Mr P's consent to disclosure was obtained and Dr Rahman disclosed his medical records to the PCT on 30 November 2010, along with his detailed comments on the written complaint. However on 24 May 2011 the PCT

contacted Dr Rahman to advise that the copy records had been lost and to request another set.

16. In the event, therefore, despite 10 ½ months having now elapsed since Dr Rahman was suspended there has been no effective progress whatever in carrying out the wider review of patient records contemplated when he was originally suspended.

The position of the parties at the oral hearing

The PCT

17. The document put in by Mr Mylonas at the hearing today in response to the Directions of the Tribunal proposed that the investigation it wishes to carry out could happen in time to notify Dr Rahman of the result by 4 pm on 12 July 2011. It was proposed that the NMA investigation team should attend surgeries conducted at Dr Rahman's practice premises over one or two days "and obtain consent from patients who attend for consultations". He further told us that this could be done by the end of next week. He said, on instructions, that this method of obtaining patient consent was used by NCAS assessors and he could see no proper reason to object to it. The target was 30-50 sets of records.
18. Thereafter the records of those patients would be considered by at least 2 members of the investigative team, each taking no more than a day and a half. The team would then prepare a report by 29 June to be considered by the PCT "and a decision taken as to whether further action is necessary". In answer to questions from the Tribunal Mr Mylonas explained that if no further cause for concern were found, a decision could be taken not to proceed further and Dr Rahman so notified before 12 July, but if further cause for concern were found a further application for an extension of suspension beyond that date would be made (he did not specify for how long). He accepted that if that were to happen a heavy burden would lie on the PCT if it wanted to obtain such an additional extension from the Tribunal.
19. Mr Mylonas conceded that effectively "our investigations have not yet occurred", and that from Dr Rahman's perspective the use of the letter dated 29 October 2010 which said that silence implied consent, and the subsequent events over the 29 patients, was entirely unsatisfactory. The burden of Mr Mylonas's submissions was to suggest that nevertheless Dr Rahman had tried to "thwart" the PCT's investigation. The evidence for "thwarting" he relied on was principally the letter referred to at paragraph 14 above. He further submitted that the Tribunal should focus on the way forward, whatever might be said about the failure to progress in the last 10 ½ months. He said the PCT had not sent out a further letter to the patients, seeking positive consent to disclosure, so as to avoid causing those patients concern.

20. Mr Mylonas accepted, in answer to questions from the Tribunal, that the investigation and the suspension were different issues, but the PCT joined the two together because of patient safety concerns. Those concerns remained the same as at 8 July 2010 when Dr Rahman was originally suspended. The point was not to punish the PCT for unsatisfactory delay, but to consider patient safety. He drew attention to Dr Budd's report (B/3/246, para 59) which he said conceded that one of the test results required some further investigation, but Ms O'Rourke pointed out that Dr Budd went on to qualify that at paragraphs 60 and 61 in which he said among other things that the subsequent discharge letter from the Consultant stated "I have not therefore changed anything today, but will contact him if bloods show any problems" went some way to an understanding of why no action was taken. The Tribunal further noted that this test result was one which was received and ticked for scanning into the records by another doctor and not Dr Rahman.

Dr Rahman

21. Ms O'Rourke QC outlined Dr Rahman's medical career to date, emphasising that there were no previous complaints, and that this arose from a single complaint which in itself was directed to other agencies in addition to Dr Rahman, and was insufficiently serious in relation to Dr Rahman to warrant suspension. She told us that when the same material had been put before the GMC Interim Orders Panel (which applies a similar test for suspension) that Panel had declined to suspend Dr Rahman from the Register. She submitted that we should stop this suspension now otherwise the PCT would get away with inaction over 10 ½ months of suspension to date, to the detriment of Dr Rahman. The PCT had public duties but also responsibilities to the doctor. We should not let the PCT off the hook but look at it from the perspective of the doctor. Nothing had been done since 8 July 2010. She contrasted that with the active approach by the PCT between receipt of the complaint and 8 July 2010. She illustrated the PCT's failure to pursue further investigation by reference to the subsequent complaint on behalf of Mr P (see above) about which nothing had been done since Dr Rahman disclosed the records in November 2010.
22. Ms O'Rourke submitted that there was no answer to the inactivity of the PCT in its opening statement lodged with the Tribunal, except to say that they had been "thwarted" but not why they had taken no effective steps to secure disclosure.
23. Dr Rahman had not required patient consent before releasing their records to thwart the investigation but had done so after taking advice from his Defence organisation. It was right that such consent should be obtained. She submitted that it was not a big job to get proper

consent, and the PCT must have accepted it was the appropriate way to proceed otherwise why did they bother with the considerable expense of a mailshot to 3500 patients.

24. So far as the current proposals to advance the investigation were concerned, Ms O'Rourke said that the PCT knew they would not be able to use the 29 patients by March 2011 and drew our attention to the fact that her solicitors had asked in May "what are you doing", but the first response was last night when Mr Mylonas's document was received. She outlined a number of concerns about the current proposal, including:
    a. Dr Rahman and his advisers were not happy about the proposal to solicit patients in the reception area which was open and public, without obvious access to a private area, and was shared with other GP practices;
    b. It would be unsatisfactory to solicit patients before they went in to see their GP when they might be anxious and focused on their own problem, when any explanation of the purpose would risk raising the patient's concerns and anxieties about this GP practice;
    c. The PCT had not produced a proposed script for seeking consent: many of the practice patients were poor English speakers, who needed particular care and explanation;
    d. After the consents had been obtained and the records were disclosed, the NMA investigation team would just be looking at the documents; neither the patients nor the doctor would not be there to put the records in context (she gave examples of how the presence of certain underlying conditions could put a test result in a different light);
    e. She was dismissive of the suggestion that the exercise described could be completed by 29 June, bearing in mind the time taken to produce the first report into a single patient complaint and the time taken to respond to Dr Budd's criticisms. She calculated that 13 working days would be available to prepare the report by the time the initial consents had been obtained.
25. Ms O'Rourke did not suggest that the concerns could not be addressed but that it would require "negotiation" to satisfy the legitimate concerns.
26. She submitted that in any event it was highly probable that the report which would be produced would identify some concern which would be the basis of a further application to extend the suspension for a further 6 months. He would be aged 65 next birthday and had been out of practice for 10 ½ months, so would inevitably become slightly de-skilled.

27. Her case was that the PCT should not be granted this extension of the suspension and if we were minded to do so we should make clear that "this was it" and it was very unlikely that any further extension would be granted.

Consideration

28. The parties agree that the need to conduct an investigation into whether there is a pattern of failings in dealing with other patients' test results is a separate issue from the necessity to suspend Dr Rahman while that investigation is conducted. The PCT contends that suspension remains necessary in the interests of patient safety (i.e. the first limb of Reg. 13 (1) (a) which deals with the protection of members of the public). It was not contended before us that the second limb ("otherwise in the public interest") is engaged.
29. The argument, though not expressly articulated, is that if there were failures in relation to one patient which were serious and could have imperilled his welfare, and if those failures might reflect Dr Rahman's practice and clinical standards generally, further patients could be imperilled if he continued to practise during the investigation. The only proxy evidence we have for the existence of such a risk is the existence of other complaints (whether to the Practice, to the PCT itself or to the GMC, and whether from patients or from hospital doctors). We have no such evidence, and indeed can infer that no complaints were made, else they would have been referred to at the time of the PCT Panel hearing, or following the referral of this matter to the GMC.
30. In considering whether the evidence persuades us that a further period of suspension is necessary today, we must first look at the material which is relied on to suggest serious and potentially widespread clinical failures. There is no new material before us to support the concerns, since the original NMA report. Unlike the PCT Panel we also have Dr Budd's report as well as the detailed explanations in Dr Rahman's own witness statement. We also draw on the experience and expertise of the members of this Tribunal.
31. The findings of the NMA report that there were clinical failings in actioning test results were confined to an investigation of one patient with an exceptionally complicated history including heart disease, hypertension, hyperlipidaemia, obesity, Type II Diabetes with complications including maculopathy, nephropathy, peripheral neuropathy and peripheral vascular insufficiency, bilateral osteoarthritis, Guillain Barre Syndrome, Irritable Bowel Syndrome and metastatic prostate cancer, who was under the care of 11 Consultant-lead specialist clinics to which he had been referred by Dr Rahman. Only two of the alleged failures to action results were by *Dr Rahman personally*, and there are cogent reasons appearing in the other material we have seen (examples of which are referred to at

paragraphs 12 and 20 above) why we should be cautious about inferring that blame will attach to Dr Rahman from those findings. We make no findings about the criticisms but even taking them at face value we find it difficult to justify suspending a doctor who has served his local patient community for 23 years or more without any evidence of blame or criticism. The more so if the period of suspension we are invited to sanction will amount to a minimum of 12 months in total.

32. We considered the submission that in the absence of a proper and effective complaints system we could not place much reliance on the supposed absence of complaints, but in our view there would have to be a mischievous complaints system designed to block or filter out complaints for that to be achieved. Moreover we note that the complaint concerning DJ did surface by the simple expedient of telephoning the PCT PALS system, which is there in part to deal with such complaints, and do not accept that others with a grievance could not do the same thing.
33. There is no reason why the investigation should not proceed whether or not Dr Rahman is suspended, and indeed if it can be concluded as swiftly as the PCT now suggests, a result will be known within a month and a decision taken whether to remove, or contingently remove, Dr Rahman from the List, so that a final decision conferring protection on patients (if required) could be taken swiftly and on much better evidence than currently available.
34. If, contrary to our views on the seriousness of the grounds on which suspension is sought, there is sufficient in the NMA report to necessitate suspension, we would conclude that an extension of that suspension to 12 July is not justified and should not be granted.
35. The processes adopted by the PCT to conduct its larger review were flawed and were not timely. We see force in the criticisms made by Ms O'Rourke. That wider investigation is its sole reason for seeking the extension. No effective step has been taken by the PCT to progress it. As Mr Mylonas conceded, "our investigations have not yet occurred". There was a very small response from patients to the original PCT letter and only now is it seeking to engage with patients to secure consent to disclosure of their medical records.
36. The evidence relied on does not satisfy us that Dr Rahman was thwarting the process as claimed by him. We find it difficult to understand how it could ever have been thought that patient consent was not necessary for the disclosure of medical records to investigators appointed by the PCT and which might foreseeably then be referred to in disciplinary proceedings, or how it could ever have been thought that consent could be implied from silence as suggested by the letter to patients of October 2010.

37. Moreover, if the PCT reached the view that Dr Rahman was thwarting them, that is a judgement based on a course of communication between them, and if the PCT reached that view it appears to have taken no effective step to overcome it, for example utilising the powers available to it under the GMS contract. This Tribunal has no powers to order disclosure of records for the purpose of enabling the investigation to proceed and an extension of suspension will not of itself remedy the lack of disclosure.
38. The PCT's conduct of the investigation does not in any degree satisfy the Department of Health guidance to which we referred, which states among other things at 18.5: "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."
39. Having regard to the totality of the evidence we find no reasonable excuse for the PCT's failure to progress its wider investigation. Balancing the conduct of the investigation during the last 10 ½ months against the nature of the risk to patients relied on by the PCT we do not consider it necessary to extend the suspension.
40. Even if we considered that the history was not such an obstacle to extension, the burden is on the PCT to satisfy us that the process described to make the failures of the past 10 months could be concluded within the next 6 weeks. We are not so satisfied. We take into account in reaching this view the submissions made by Ms O'Rourke, in particular as to the processes involved in reaching a conclusion, and notwithstanding the submission by Mr Mylonas that Dr Kheraj believes it can be done. The concerns raised on behalf of Dr Rahman about the proposed process of seeking urgent patient consent are proper concerns and are likely to involve discussion and fine tuning to avoid distress or anxiety to patients and avoid unjustified damage to Dr Rahman's reputation; this was not factored in to the time scale outlined by Mr Mylonas. Consideration of any further NMA report and consequent decision by a decision-making body whether to proceed against Dr Rahman (therefore apply for a further extension) is a process which will itself take significant further time, and is not a decision to be taken at single officer level.
41. We remain mindful of the safety of the public. But in all the circumstances we are not satisfied that an extension of Dr Rahman's suspension is necessary for the protection of members of the public, nor is it otherwise in the public interest. Indeed the public interest may not be well served by a continued suspension of an experienced GP. Nor would it be proportionate to the perceived risk to extend that suspension. We bear in mind that, as both

parties agree, the conduct of the wider investigation can go ahead independently of any suspension. We see no reason why that should not still happen in a timely but measured way

Duncan Pratt

Tribunal Judge

2 June 2011