THE FAMILY HEALTH SERVICES APPEAL AUTHORITY

CASE NUMBER 14633

Heard on: 12th 16th 17th 18th and 19th March 2009

Appeal Panel: Mrs D Shaw Chairman
Dr J Lorimer Professional Member
Mr W Nelson Member

BETWEEN

DR DHANAPALA ARACHCHIGE PIYADASA
(GMC Registration No: 2910006)

Appellant

and

WANDSWORTH TEACHING PRIMARY CARE TRUST

Respondent

Appeal against the decision of the Respondent to contingently remove the Appellant from its Performers List pursuant to section 12 of The National Health Service (Performers Lists) Regulations 2004

DECISION WITH REASONS

A. Preliminary matters

1. The appeal was held at the Care Standards Tribunal, 18 Pocock Street, London SE1.

2. Prior to the commencement of the hearing all three panel members had signed a declaration confirming they had not had any prior interest or involvement in the appeal which would preclude them from considering the evidence in an independent and impartial manner.

3. The persons who appeared before the Appeal Panel were:

Dr Dhanapala Piyadasa	- the Appellant
Mr John de Bono	- Counsel for the Appellant
Ms Kate Olpin (RadcliffesLeBrasseur)	- Solicitor for the Appellant
Dr Marcus Bicknell	- Witness for the Appellant

Ms Fenella Morris	- Counsel for the Respondent
Ms Annabel Rumble (Capsticks)	- Solicitor for the Respondent
Mr David Jamieson	- Witness for the Respondent
Dr Emmanuel Baikie	- Witness for the Respondent
Mr Peter Constable	- Witness for the Respondent
Nurse Claudette Boyce Lynch	- Witness for the Respondent
Mr Peter Meager	- Witness for the Respondent
Ms Geraldine Blache	- Witness for the Respondent
Ms Kirsty Sibandze	- Witness for the Respondent
Dr Brian Fine	- Witness for the Respondent

B. History of the Appeal

NB. Reference throughout to parties and documents is as follows:

Dr Piyadasa	*= Dr Piyadasa /Appellant*
Wandsworth Teaching PCT	*= the PCT /Respondent*
Bundle	*= B*
Appellant's Supplementary Bundle	*= ASB*
File	*= F*
Tab	*= T*
Page(s)	*= p(p)*
MedicalRrecord	*= MR*
Inmate Medical Record	*= IMR*
Witness Statement	*=WS*
Good Medical Practice	*=GMP*

1. In April and May 2007 the Governor of HMP Wandsworth wrote to the PCT expressing concerns about Dr Piyadasa's performance and the fact there had been 30 prisoner complaints about him, 13 of which had been upheld between January 2006 and March 2007. The complaints included poor communication, not carrying out physical examinations, having a dismissive manner, being uncooperative, not returning calls and refusing to see patients.

2. The PCT commissioned Acredita & Associates to undertake an investigation into Dr Piyadasa's practice to clarify the concerns that had been raised and to determine whether any further action was required. The findings and conclusions of the investigation were set out in a report dated 13th August 2007 ("the Acredita report") *(B2 T4 pp49-72)*, which highlighted three main areas of concern regarding allegations of sub-standard performance. These were:
    - Consultation style and underlying attitudes regarding the doctor-patient consultation
    - Written communication
    - Continuing Professional Development (CPD) and identifying personal learning needs

3. The PCT wrote to Dr Piyadasa on 16th April 2008 *(B2 T7 pp77-79)* to inform him that the PCT Contractor Performance Group had recommended that the PCT should consider his contingent removal, which it did at a hearing on 4th June 2008, at which it decided to contingently remove him subject to the conditions set out in the Minutes of the Hearing *(B2 T9 pp82-92)*.

4. The PCT notified Dr Piyadasa of his contingent removal from the PCT's Performers List in a letter dated 17th June 2008 pursuant to its powers under Regulation 12 of the National Health Service (Performers Lists) Regulations. 2004 ("the Performers Lists Regulations"). That letter set out the conditions to which his continued inclusion would be subject *(B2 T10 pp93-94).* These were:

    - That he be appraised by a fellow GP appointed by the PCT within one month.
    - That as part of this appraisal a Personal Development Plan (PDP) be agreed with the Medical Director of the PCT within six weeks.
    - The PDP had to include a requirement to undertake training and development of his consultation skills and style, and following this training and development he had to pass an assessment of his consultation skills and style within three months.
    - That his handwritten entries in medical records were legible. To assess those he would be required to participate in an audit of his written medical records, to be undertaken three months after his return to practice.
    - That he inform the following parties that his inclusion was subject to the above listed conditions:
        - Any organisation or person employing or contracting with him to undertake any medical work
        - Any locum agency or out of hours service he was registered with or he applied to be registered with (at the time of application)
        - Any prospective employer (at the time of application)
        - The Director of General Practice Education at the London Deanery of GP Postgraduate Education.

    The letter also indicated that it was the PCT Panel's view that an immediate return to general practice would be detrimental to the outcome of the training and development of Dr Piyadasa's consultation skills and that over the next three months he should focus on achieving the best outcome from the training and development and not to return to work. The PCT also indicated it would arrange a review of these conditions for September 2008.

5. On 14th July 2008 Dr Piyadasa served Notice of Appeal on the PCT disputing this decision and setting out a concise statement of his grounds of appeal pursuant to Rule 6 of the Family Health Services Appeal Authority (Procedure) Rules 2001 (the Procedure Rules) *(B2 T1 pp1-6).*

6. The PCT responded in a Statement dated 11th August 2008 opposing Dr Piyadasa's grounds of appeal *(B2 T2 pp7-14).*

7. Directions Hearings for the management of this appeal were held on 16th October 2008 and 19th January 2009.

C. The Appeal

(i) Jurisdiction

The National Health Service (Performers Lists) Regulations 2004
The regulations applicable to this appeal are:

10 (3) The Primary Care Trust may remove a performer from its performers list where any of the conditions set out in paragraph (4) is satisfied.

(4) The conditions mentioned in paragraph (3) are *(inter alia)* that –
(a) his continued inclusion in its performers list would be prejudicial to the efficiency of the services which those included in the relevant performers list perform ("an efficiency case");

12 (1) In an efficiency case … the Primary Care Trust may, instead of deciding to remove a performer from its performers list, decide to remove him contingently.

(2) If it so decides, it must impose such conditions as it may decide on his inclusion in its performers list with a view to -
(a) removing any prejudice to the efficiency of the services in question (in an efficiency case)

(3) If the Primary Care Trust determines that the performer has failed to comply with a condition, it may decide to -
(a) vary the conditions imposed;
(b) impose new conditions; or
(c) remove him from its performers list.

15 (1) A performer may appeal (by way of redetermination) to the FHSAA against a decision of a Primary Care Trust mentioned in paragraph (2) by giving notice to the FHSAA.

(2) The Primary Care Trust decisions in question are *(inter alia)* decisions –
(e) to impose a particular condition under regulation 12, or to vary any condition or to impose a different condition under that regulation

(3) On appeal the FHSAA may make any decision which the Primary Care Trust could have made.

(6) Where the FHSAA on appeal decides to impose a contingent removal -
(a) the Primary Care Trust and the performer may each apply to the FHSAA for the conditions imposed on the performer to be varied, for different conditions to be imposed, or for the contingent removal to be revoked; and
(b) the Primary Care Trust may remove the performer from its performers list if it determines that he has failed to comply with any such condition.

(ii) Preliminary issues

1. Standard of Proof

1.1 The parties agreed at the Directions Hearings held on 19th January 2009 that the civil standard of proof would apply to these proceedings.

2. Procedure Rule 41(7)

2.1 Counsel for the Appellant submitted a supplemental skeleton argument relating to the admissibility of fresh/further evidence by the Appellant under Procedure Rule 41, contending that:

2.1.1 The Respondent was not allowed to rely on any additional evidence at this hearing

2.1.2 This was not a matter of discretion but simply an application of the rules that Parliament did not intend the Respondent could adduce further evidence at the appeal stage.

2.1.3 Alternatively, if a power to admit further evidence was to be implied then it was a power to be used sparingly and with great caution because to do otherwise would be to offend against the rules and would be unfair to the Appellant (see *Ladd v Marshall [1954] 1WLR 1489* for High Court practice).

2.1.4 It would be wrong to permit the Respondent to call any witness evidence at this appeal because, although available, no such evidence was called at the original hearing.

2.1.5 It was unfair to adduce far more extensive evidence than was before the PCT Panel and the Respondent was not entitled to a second bite of the cherry, thereby effectively by-passing the original hearing as a forum for evidence.

2.1.6 Rule 41(2) states: *"**Subject to this rule**, the panel shall conduct the hearing in such manner as it considers most suitable to the clarification of the issues before it and generally to the just handling of the proceedings."* This meant the conduct of the hearing was subject to Rule 41.

2.1.7 Whilst Rule 41(3) states *"The parties shall be heard in such order as the panel shall determine and they shall be entitled to give evidence, **to call witnesses**, to question any witnesses and to address the panel both on the evidence and generally on the subject matter of the appeal or the application, as the case may be"*, this did not mean either party could call any witnesses it wanted.

2.1.8 Whilst Rule 41(5) states *" Evidence before the panel may be given orally or, if the panel so directs, by written statement, but **the***

panel may at any stage of the proceedings require the personal attendance of any maker of a written statement" this would only apply where the panel had questions or concerns relating to the witness statement.

2.1.9 Whilst Rule 41(6) states *"The panel may receive evidence of any fact which appears to it to be relevant, notwithstanding that such evidence would be inadmissible in proceedings before a court of law, but shall not refuse to admit any evidence which is admissible at law and is relevant"* this only went to the question of admissibility as opposed to what evidence the parties were entitled to call.

2.1.10 Rule 41 (7) states *"At any hearing the panel may, if it is satisfied that it is just and reasonable to do so, permit a party to rely on grounds not stated in his notice of appeal or, as the case may be, notice of application, or his reply in either case and**, in respect of an appellant, to adduce any evidence not presented to the respondent Health Authority before or at the time it took the disputed decision***" which meant only one party, i.e. the Appellant, could present new evidence if the panel permitted him to do so.

2.2 Counsel for the Respondent did not accept the Appellant's interpretation of Rule 41, contending that:

2.2.1 A FHSAA panel's jurisdiction was unique because it carried out a complete rehearing of the case. It does not look at a transcript of the previous hearing like the Court of Appeal but goes back and looks at everything from the beginning.

2.2.2 A PCT decision is not a court-made decision but a decision of an administrative body, so the FHSAA appeal is the first opportunity for a court or a court-type panel to look at it.

2.2.3 The Appellant was asking the panel to take a restrictive view of Rules 41(6) and (7) but the Respondent submitted the panel has a wider power than that of the Court of Appeal and its key function was to balance the Appellant's interests against the public interest of having safe NHS doctors.

2.2.4 The Appellant was trying to say that because there was an express power for an appellant to adduce new evidence under Rule 41(7), that implied a restriction on the Respondent, but the Respondent submitted express Parliamentary words cannot imply a restriction where Parliament has not said anything at all.

2.2.5 The evidence in question was brought about by the panel's express directions pursuant to submissions made on behalf of the Appellant that it was unsatisfactory that he did not have material underlying the Acredita report. Yet the panel was now being asked to exclude that evidence when it only had a power to exclude

irrelevant and inadmissible evidence under Rule 41(6). As this evidence dealt with key allegations against the Appellant it was not irrelevant. It would be perverse to suggest witnesses' interview notes were admissible but their statements were not.

2.3 In response, Counsel for the Appellant submitted that when directions were given, the extent of the new evidence the Respondent sought to rely on was not known.

2.4 Having carefully considered all of the submissions, the panel was of the unanimous view that the purpose of the evidence in the witness statements and the fact these witnesses were to be called, was to substantiate the evidence of those witnesses recorded by the authors of the Acredita report upon which the Respondent relied when making its decision. As such, they did not consider it to be new evidence that ought to be excluded, either on grounds of fairness to the Appellant or on a restrictive interpretation of Rule 41.

(iii) Evidence

Over the course of the hearing, which lasted for five days, we were presented with a large amount of written and oral evidence, which included extensive files of medical records, witness statements and over 160 pages of notes of the oral evidence. For the purposes of our consideration of the evidence and this decision, we agreed the best course to adopt would be to examine the relevant parts of the Acredita Report *(B2 T4 pp49-72)* and the evidence we had seen and heard in relation to its findings on the principal issues which had been raised by the PCT in support of its allegations of prejudice to efficiency of services, before fully considering those issues. and then indicate if and why we did or did not agree with the PCT's decision.

(iv) Principal Issues

1. Clinical knowledge and care

1.1 Dr Baikie gave evidence *(B3 T8 WS pp49-51 para 7)* that he could not remember any clinical issues where Dr Piyadasa did not perform to an accepted standard and the issues seemed to arise out of his dismissive attitude. He confirmed at the hearing there were no issues in relation to Dr Piyadasa's clinical competence.

1.2 Nurse Lynch confirmed at the hearing that Dr Piyadasa never caused harm to a patient

Acute disease management

1.3 The Acredita report *(B2 T4 p54)* found that there were examples in the medical records suggesting both good and bad practice in relation to acute disease management, although limited record keeping and poor legibility made it hard to assess. Evidence from interviews suggested that there were no noteworthy problems with clinical knowledge, but on occasions, a lack of time given to the patient prevented complete and adequate management of the clinical problem

1.4 Dr Fine gave evidence regarding the findings in the Acredita report relating to acute disease management. He considered that failure to document an appropriate history and/or examine the patient meant that it would be much harder for another doctor to take over care of the patient when Dr Piyadasa was not available, and to make an informed clinical decision, particularly in an emergency (*2nd WS B3 T2 p16 para 12).* He was taken at the hearing to the medical records for patient 6457 *(B1 F1 T14 p204 and 2nd WS B3 T2 p16 para 12)* as an example of poor practice in acute disease management, where in an entry dated 09/02/07 he felt that Dr Piyadasa had changed the medication for a patient with a history of depression from Venlafaxine to Fluoxetine without taking a history, so that it would not have been possible to monitor the effect (and possible complications) of changing anti-depressants.

1.5 Dr Piyadasa gave oral evidence that despite having recorded no evidence of depression, he had prescribed another anti-depressant, as it was necessary to wean patients off anti-depressants slowly to avoid relapse. He would be able to review the effects of the change of medication as the patient was on his wing. It was hard to record baseline impressions in the short appointment time available, which was why he had referred the patient for full assessment to the Psychiatric Inreach Team (PIT). When asked how another doctor would be able to evaluate how this patient was doing on Fluoxetine on the strength of his entry in the notes, he replied that the doctor would have to ask the patient how he was doing.

1.6 Dr Bicknell's evidence *(1st Report B3 T4 pp105-106)* was that this entry showed anti-depressants had been discussed, the patient complained of side effects from Venlafaxine and Dr Piyadasa agreed to change this to Fluoxetine. The prisoner was noted to be abusive and argumentative and swore at the doctor. Dr Bicknell considered Dr Piyadasa's care for this patient appeared to be of a high standard with excellent clinical decision-making.

1.7 At the appeal he reiterated that he considered Dr Piyadasa had acted reasonably; the notes indicated it was a consultation which evolved as Dr Piyadasa was writing, with the patient saying he was on Venlafaxine, Dr Piyadasa assessing whether to continue it and why, before choosing another anti-depressant with different qualities, i.e.

more stimulating. Dr Bicknell felt there was a sense the patient accepted that, although the notes showed it was not an easy consultation with the patient being abusive as is very common in prison. He also considered the entry dated 28/02/07 by the Primary Care Mental Health Team showed Dr Piyadasa had ensured the patient received follow-up and that the new medication was working better than the previous medication, so it had proved to be a good choice.

1.8 Dr Fine was also taken at the hearing to his pro forma for patient 5334 *(B1 F1 T12 pp173-174 and 1st WS B3 T1 p5 paras 21 and 22)* (no medical records) where he noted from the IMR that Dr Piyadasa had stopped the patient's Zopiclone in possession without noting a reason for doing so although the patient had a long history of depression, leading to him recording a dispute with the patient.

1.9 In his oral evidence relating to patient 8097 *(B1 F1 T13 pp196-197)*, Dr Fine considered the note Dr Piyadasa recorded of the patient being angry suggested he was not being allowed to talk and explain his various requests (for medication in possession, to be located flat flat [a cell on the ground floor] and for an open door policy) and he would have preferred to have seen some evidence of an agreed decision with the patient.

1.10 Dr Piyadasa gave oral evidence that the policy at HMP Wandsworth was not to have any psychotropic medicine in possession. This was an absolute rule for some medication but in very exceptional circumstances a patient would need an assessment before obtaining other medicine in possession.

1.11 In relation to patient 8097, he would have been happy for him to be assessed for medication in possession, but he would not make this decision because Dr Baikie had prescribed not in possession only the week before.

1.12 Dr Bicknell thought *(1st Report B3 T4 pp104-105)* the notes showed this patient blamed Dr Piyadasa for many things outside his control but felt the notes were legible, thorough, and relevant and reflected an excellent insight into a difficult consultation with a challenging inmate. He submitted Dr Piyadasa's prescribing, referral and compassionate management decisions were beyond reproach. At the hearing he gave evidence that he felt the primary reason for this consultation was for the patient to seek a special location and for his cell door to be kept open. He submitted that prison doctors are in a unique position to confer benefits on prisoners and it is very common for prisoners to seek favour from a doctor within a prison setting. He felt if Dr Piyadasa had agreed to prescribe medication in possession it would have undermined Dr Baikie or may even have been dangerous, so referral for assessment was the reasonable and right thing to do.

Chronic Disease Management

1.13 The Acredita report *(B2 T4 pp54-55)* found that chronic disease management ("CDM") was very poorly organised and implemented at HMP Wandsworth. At some point in the recent past, the work of structured CDM was delegated to nursing staff, only for the nursing staff levels to be reduced such that the work could not be undertaken. The work of all the doctors in CDM was thus carried out with very limited support. Regardless of this impediment, the interviews undertaken and the records examined showed that Dr Piyadasa gave very little thought to the important task of CDM during his consultations with patients.

1.14 Dr Fine gave evidence regarding the findings in the Acredita report relating to chronic disease management. He was taken at the hearing to his notes for patient 6118 *(B1 F1 T12 p105)*, the medical records *(B1 F4 T26 p1251)* and his witness statement *(2nd WS B3 T2 p18 paras 21-22)* as an example. In his witness statement he noted that despite the last entry from the patient's previous prison dated 30/11/06 recording recent episodes of chest pain radiating into the left arm and the patient using Nitro spray (a treatment for acute angina) and mention being made of his need for a stress ECG the next week, when Dr Piyadasa saw this 62 year old patient on 12/12/06 none of this was recorded as having been explored by him and there was no record of any intention for follow up or referral for further care. In Dr Fine's opinion a man of this age with recent acute angina was at risk of having a heart attack and a competent doctor should have explored this matter at the consultation and ensured that arrangements were made or in place for an urgent cardiological examination, and arranged to have the patient's progress reviewed again very soon in the prison.

1.15 Dr Piyadasa submitted in his witness statement *(2nd WS B3 T2 pp64-65 paras 11-13)* that he saw this patient in reception, where 75-100 prisoners could be admitted in an evening and his function was to screen to identify any urgent medical problems to be addressed that night, before the patient was allocated a wing where he would be seen at a Wellman Clinic the following day, where other medical issues could be identified and addressed. There was no reference to ongoing cardiac investigations in the notes that would have been available to him when he saw the patient. As the patient had experienced an episode of chest pain he graded him for no strenuous work as a precautionary measure, but he only saw the patient on this one occasion after which he would be under the care of a wing doctor.

1.16 Dr Bicknell did not comment on this aspect of the consultation although he considered *(1st Report B3 T4 pp110)* Dr Piyadasa's entry was for a routine reception screen and labour grading with crystal clear prescribing.

1.17 Dr Fine also gave evidence in relation to the management of patient 5227 *(WS B3 T2 pp19-20 paras 23-27)*, who was a 50 year old man with hypertension who had blood tests taken in August 2006, which he considered showed evidence of renal failure by virtue of a slightly raised creatinine level. There was also a slightly raised cholesterol level and this and hypertension were risk factors for heart disease. Someone had reviewed these results and written on them that they should be repeated in six months, but despite the patient being seen several times after that for various ailments (not always by Dr Piyadasa) and on 25/05/07 by Dr Piyadasa *(MR B1 F2 T21 p727)*, who carried out an examination, no blood pressure measurement was taken and there was no mention in the records of any follow up blood tests. It was only when Dr Baikie saw the patient on 23/07/07 that his blood pressure was taken, his medication reviewed and arrangements made for a follow up blood test the next day. Whilst Dr Fine did not consider Dr Piyadasa was solely at fault for not organising follow up blood tests, he felt the records suggested that if Dr Piyadasa had been thorough in his consultation on 25/05/07, he would have seen that this patient was at risk of developing renal failure, was overdue for his follow up blood test and could have taken action then to organise it.

1.18 At the hearing Dr Fine also submitted Dr Piyadasa had been clinically incorrect to say the results did not show anything unusual or indicative of renal failure and when he came across this case he had taken steps to alert the prison authorities and have the patient seen for blood tests by Dr Baikie a couple of days later.

1.19 Dr Piyadasa submitted *(2nd WS B3 T2 pp65-66 paras 14-17)* that he was the doctor available to review the results when they came in but they did not show anything unusual or indicative of renal failure. He had advised the blood tests should be repeated in six months time as a precautionary step, since the cholesterol and triglycerides were slightly raised. His first contact with this patient was on 14/12/06 when he treated him for an abscess on the groin, and he next treated him acutely for cough and cold symptoms on 08/05/07, but as he was not a resident of Dr Piyadasa's wing, this patient was routinely under the care of another doctor during the period criticised by Acredita. When Dr Piyadasa saw this patient on 25/05/07 when he requested a single cell because of high blood pressure, Dr Piyadasa declined as his blood pressure had been monitored regularly with no evidence of high blood pressure since his admission in 2004.

1.20 At the hearing Dr Piyadasa also submitted that the results had been shown to him in isolation and he had written the blood tests should be repeated in six months so the nurse would show this to the doctor on the patient's wing. Dr Fine's interpretation of the results showing early stages of chronic renal disease was only his opinion.

1.21 Dr Bicknell's evidence at the hearing was that in his opinion there was no indication of renal failure, because there would not have been a

normal urea reading as was the case here. He submitted there could be many reasons for the creatinine level being slightly raised and he had no concerns the patient's safety had been compromised or that he would develop renal failure within a considerable period of time.

Maintaining trust

1.22 Although we consider this heading in the Acredita report overlaps with mental health issues and acute and chronic disease management, as evidenced by the fact this section of the report includes reference to patient 5334, it also refers to patient 4413 *(B2 T4 p61)*, describing him as "a man with depression who had been managed in another prison on Trazodone, an anti-depressant drug. Dr Piyadasa refused to prescribe this drug, writing in the medical records [on 02/02/07] *(B1 F2 T20 p658)* "In my opinion, no indication for Trazodone". However, no reason for this opinion is stated and Dr Piyadasa suggested Citalopram, another anti-depressant drug instead. This decision resulted in conflict with the patient. After being seen by the in-reach psychiatric team, this patient was re-started on treatment with Trazodone [in possession]."

1.23 The Acredita report goes on to cite this case as an example of poor practice in handling complaints *(B2 T4 p61)*, on the basis there is no noted record of any negotiation between Dr Piyadasa and the patient, Dr Piyadasa merely states what the situation is, and then informs the patient he has the right to formal complaint if he disagrees with this.

1.24 Dr Fine gave evidence *(WS B3 T3 pp29-31 paras39-44)* that he was not sure whether the computerised IMR record from Brixton prison recording the patient was on Trazodone would have arrived by the time of this consultation. None the less, he was concerned as to why Dr Piyadasa prescribed an alternative if he found no evidence of clinical depression. There was no contra-indication to change the drug and the in-reach team on 24/04/07 took this view. He also felt this record provided evidence of Dr Piyadasa's poor consultation skills, as there was no evidence of dialogue with the patient about his medication and the record suggested a very one-sided consultation which did not appear to resolve the problem.

1.25 Dr Piyadasa gave evidence *(WS B3 T2 pp68-69 paras 28-34)* that at the consultation on 02/02/07 he saw no record of Trazodone ever having been prescribed in the past but noted he had already written up Citalopram for the patient on 12/01/07. At the consultation the patient demanded Citalopram in possession, but it was not prison policy to prescribe anti-depressants in possession; they had to be obtained daily from the nurse as prescribed. The notes show he advised the patient of his rights and the routes of complaint and referred him to the Mental Health Team for further assessment, which advised the patient on 21/02/07 to continue with the Citalopram. When he saw the patient again on 20/04/07 there was no evidence of clinical depression or mental health problems, but he was still demanding Trazodone. As Dr

Piyadasa noted he was already prescribed Citalopram, although he said he was not taking it, Dr Piyadasa again referred him to the psychiatric team for a second opinion, and when he was reviewed by them on 24/04/07 he was prescribed Trazodone for 7 days in possession and review. Dr Piyadasa would have been reluctant to do this as it was mainly a sedative and many prisoners abused sleeping medication and used it as currency. He felt that twice referring this aggressive patient to the prison psychiatric team for a second opinion was a fair compromise and means of negotiation, given the brevity of the consultation, which would have lasted 5-10 minutes and the difficulty in establishing a rapport with some patients in the prison environment, where they are seen by different staff at different times and because of their situation and attitudes towards and perception of prison staff.

1.26 At the hearing Dr Piyadasa reiterated that in the very short consultation time available he had to go through the files and read the previous written notes and he only had time to record his impression, although he normally had a checklist. Trazodone was a very old drug that was currently not used as regular medication; it was mainly a sedative. By the time the patient was assessed by the Mental Health Team for a second time [on 24/04/07] his printed notes showing Trazodone in possession had arrived from Brixton prison.

1.27 Dr Bicknell's opinion *(B3 T4 pp107-108)* was that Dr Piyadasa was wise to decline psychotropic medication in possession in prison and many prisons have a written policy not to do this due to the risks of overdose, dealing, poor compliance and bullying. When the prisoner threatened to complain, the doctor professionally proceeded with the referral to the nurse, who supported his decision. When the patient continued to demand Trazadone at review, Dr Piyadasa wisely referred him to the prison in-reach psychiatric team for a third opinion. Dr Bicknell was surprised the in-reach team prescribed 7 days Trazodone in possession.

1.28 At the hearing he repeated that he thought it was poor practice to prescribe psychotropic medication in possession and submitted a patient wanting this suggested he wanted more control. He felt the in-reach team undermined all the other doctors and he noted the drug charts showed this decision was subsequently reversed in line with prison policy. *(B1 F2 T20 p701)*

Referring patients

1.29 The Acredita report *(B2 T4 pp63-64)* found that Dr Piyadasa's external referrals were of variable standard, but generally adequate. It gave two examples of good practice and two of bad practice, the medical records for neither of which were available. However, the report referred to the evidence of Peter Constable (a primary care officer at HMP Wandsworth), in relation to one of these patients, which was that the prisoner was admitted to HMP Wandsworth having had facial surgery following a road traffic accident. He was seen by Dr Piyadasa with

continuing facial pain and swelling, but Dr Piyadasa refused to do an x-ray or take any other action. Peter Constable asked the radiographer to do an x-ray, which they considered revealed significant problems with the orthopaedic screws in the patient's jawbones, but Dr Piyadasa continued to refuse to refer or otherwise treat this patient. Eventually, after transfer to another prison, the patient was re-admitted to hospital.

1.30 In his witness statement *(B3 T7 pp47-48)* Peter Constable added that his main concern was Dr Piyadasa's communication skills and attitude to both patients and colleagues and the fact he was not approachable to a patient who wanted to explain a problem.

1.31 Peter Constable gave evidence at the hearing that he had asked Dr Piyadasa what he had thought of the patient and found him rather dismissive, saying not to worry, the patient would be fine. As he was still worried, Peter Constable approached Dr Baikie, who had indicated he could not now get involved. That was why he had approached the radiographer direct, who had taken the x-ray and discussed it with him. He had gone back to Dr Piyadasa armed with the x-ray, but he was again dismissive when he looked at the x-ray, saying there was no need for any action. The prisoner was than transferred, only to reappear at HMP Wandsworth a few weeks later after he had been to St George's Hospital for surgery. Peter Constable did not know who at the other prison had referred him to hospital.

1.32 Dr Piyadasa submitted *(B3 T3 p96)* that Peter Constable had suggested a patient by-passed him to get x-rays but whilst there had been an x-ray machine at the prison and a visiting radiographer twice a week, that was stopped. As a result, if a patient needed an x-ray, two officers would need to escort him to hospital, requiring a great deal of planning and resources, so clinical judgment was required with x-rays being reserved for needy patients.

2. Consultation style and communication skills

2.1 The Acredita report concluded *(B2 T4 pp66-67)* that Dr Piyadasa's brusque manner of consulting consistently failed to comply with any modern day notion of good doctor-patient consultation, such as those of his colleagues at Wandsworth and that his failure to listen put undue pressure on his ability to make accurate diagnoses, to manage the presenting problems, and on the relationship between himself and his patients, as well as between himself and many of his colleagues. The Acredita team found only one example of where his style of consultation was deemed appropriate and that was from a prison officer. They gleaned from interviews with his other prison colleagues that the animosity created by his poor consultations only added to the workload of discipline staff whose job it was to manage the heightened tension on the wing following one of Dr Piyadasa's surgeries. Following their interview with Dr Piyadasa they also concluded he

appeared to have little insight as to how poor consultations might not serve himself or his patients to the best effect. They noted that he denied any suggestion that he did not listen or involve patients in consultations and they felt his inability to stand back and to reflect upon a growing pool of evidence supporting these claims was concerning. The Acredita team would have expected more recognition that something was going very wrong and considered the evidence pointed to Dr Piyadasa being out of kilter with the consultation styles and standards of the rest of his colleagues. Their greatest concern was Dr Piyadasa's lack of insight in relation to his beliefs and attitudes towards patients and good clinical care and outcomes. They were told in interviews with prison staff, and they also came to the opinion, that Dr Piyadasa may well have seen his role as a GP in the prison service as "discipline staff" as much as doctor. In tone, attitude and speech ("I am the doctor here" being cited regularly as an example of Dr Piyadasa's final words within a consultation) they felt that he might be in danger of neglecting his professional duty to his patients, although medical care in prisons should never be confused with a discipline role.

2.2 David Jamieson, Chairman of the Independent Monitoring Board ("IMB") at HMP Wandsworth, submitted *(WS B3 T6 pp44-46)* that the primary role of the IMB was to ensure that prisoners were treated fairly and the main method of ensuring fair treatment of prisoners was through confidential applications to the IMB. Before Secure Healthcare took over the running of healthcare at HMP Wandsworth the standards of healthcare were poor. The IMB produced critical reports in this regard and, in particular, the concerns identified related to the doctors' poor communication skills and dismissive attitude to prisoners. Review of those complaints showed those concerns arose in the main from complaints regarding Dr Piyadasa. Mr Jamieson had also observed Dr Piyadasa when walking round the prison and experienced first hand his dismissive attitude towards prisoners. He was generally appalled by his lack of professionalism on these occasions and many of his colleagues also experienced the same thing. As well as complaints about attitude and communication skills, the IMB also received complaints relating to Dr Piyadasa's medical skills and knowledge, such as inappropriate diagnosis, ignoring medical records of prisoners and displaying a lack of knowledge of mental health problems. Mr Jamieson had raised concerns regarding Dr Piyadasa at length with both the healthcare manager and the prison governor for approximately 18 months before his departure, since when the prisoners were much happier with the level of healthcare they received.

2.3 At the appeal Mr Jamieson confirmed the IMB had handed over complaints to the Head of Prison Healthcare and never to Dr Piyadasa direct. He also confirmed the IMB's concerns were exclusively related to attitude rather than clinical care.

2.4 Dr Baikie, senior doctor in the substance misuse team at HMP, gave evidence *(WS B3 T8 pp49-51)* that whilst he had not witnessed Dr Piyadasa's consultation style first hand, when he worked at the prison there was general discontent amongst the patients with the care that they received from Dr Piyadasa and a lot of complaints were made about him. There were always complaints being made by patients in the prison environment and doctors were often asked for medication which they did not consider to be in the patient's best interests, e.g. if a patient requested codeine but the doctor was concerned he was addicted to it, he might prescribe paracetamol instead, but Dr Baikie would take the time to explain why he was refusing a particular request, which generally defused the situation and the patient accepted his decision. Dr Baikie thought the rate of complaints and demands for second opinions regarding healthcare had decreased since Dr Piyadasa stopped working at the prison

2.5 All the GPs were called to meet with the healthcare governor when Dr Piyadasa worked at the prison in order to discuss the patients' dissatisfaction with the doctors' attitude during consultations, but the concerns were expressed on a general basis and Dr Piyadasa was not singled out.

2.6 He could not really remember any clinical issues which arose where Dr Piyadasa did not perform to an accepted standard; although he did not have first hand experience of this, the issues seemed to arise out of Dr Piyadasa's dismissive attitude. The nurses would prefer to approach other doctors and would often come to Dr Baikie with drug charts because Dr Piyadasa had refused to sign something off if he did not have the patient's medical records.

2.7 At the hearing Dr Baikie reiterated that he had no issues regarding Dr Piyadasa's clinical competence and when there had been a meeting in order to discuss the patients' dissatisfaction with the doctors and nurses, no criticism had been directed at Dr Piyadasa alone.

2.8 Nurse Claudette Boyce-Lynch, a nurse in primary care at HMP Brixton at the relevant time, submitted *(WS B3 T9 pp52-54)* that she did have concerns about Dr Piyadasa at the time and claimed that when prisoners first arrived at the prison, Dr Piyadasa would sometimes reduce the dose of medication which had been prescribed, even where it was visible on the label what the dose was meant to be. When patients told him what medication they usually took, Dr Piyadasa would sometimes reduce the dose in those situations as well, especially for chronic pain. Patients would often not receive any medication until Dr Piyadasa had checked the position with their previous GP, leaving them without medication for quite some time. She felt this sometimes adversely affected the patient's health and their ability to settle in prison. Whilst she knew prisoners often complain, the complaints received about Dr Piyadasa were far more frequent than about anyone else and patients would often refuse to see him at all. Dr Piyadasa's

clinical knowledge was good, but his manner with patients concerned her.

2.9 At the hearing she submitted that other doctors on reception duty would talk to the prisoners and examine them more. Dr Piyadasa would just give them a form. She did not have any concerns about his clinical knowledge and he had never caused harm to a patient. She approached other doctors with the drugs chart because she was able to spend more time with them discussing it; they were more approachable so if medication couldn't be prescribed she would then be able to better explain why to a prisoner. When asked, she agreed that other doctors would prescribe medication for a short time after first questioning and examining prisoners, but Dr Piyadasa would say "No" without trying to take a history or do an examination. She also agreed that on reception, it was the medication capable of misuse which Dr Piyadasa would reduce without having taken much of a history and this could lead to patients becoming aggressive.

2.10 Geraldine Blache, lay investigator for Acredita, gave evidence *(WS B3 T4 pp36-40)* about the interviews she had conducted with the members of prison and healthcare staff on-site, including Nurse Boyce and Dr Baikie. She also talked about her interview with Dr Piyadasa, submitting that during the interview he quickly began to demonstrate the characteristics which had been described to the Acredita team by other people they had interviewed. The main thing which was apparent was that he did not listen to what was being said or asked and constantly interrupted them whilst they formulated questions. Dr Piyadasa came across to her as someone who saw himself as a prison officer rather than as the doctor role he was employed to undertake. Throughout the interview he referred to his patients as prisoners. She was professionally affronted by this attitude and alarmed that he did not see why this distinction was important. The issues which gave most cause for concern related to Dr Piyadsasa's dismissive attitude and poor communication skills, which had the effect of severely limiting the available history on which to make his clinical decisions. Of all the issues raised during the interviews, this, combined with the reported reluctance to examine, struck her as the most alarming of all.

2.11 At the hearing, Ms Blache submitted the Acredita team had all been concerned that Dr Piyadasa had not been informed about the complaints against him; they felt he should have been. She did not think there was necessarily a distinction between being a prison GP and a GP in the community. A doctor should treat each person with respect whilst being aware prisoners can manipulate the system. The fact people were in prison did not mean they should not be looked at as patients when they needed health care, but the Acredita team were worried that Dr Piyadasa did not see them as patients as well as prisoners. They had gone into the interview with Dr Piyadasa fairly open-minded but with alarm bells ringing from what Nurse Boyce had said. Ms Blache stood by what she had said; it came across to her that

it was possible for prisoners to be punished twice by not being able to access a prison GP for healthcare.

2.12 Dr Fine's evidence was *(WS B3 T2 pp20-21)* that Dr Piyadasa's relationship with patients was one of the most significant areas of concern for the Acredita team. It was evident that he did not, on the whole, maintain a good relationship with his patients. One of the issues was his reluctance to trust patients to have medication in possession. Whilst drugs could be traded in prisons and allowing medication in possession represented a degree of risk which had to be assessed by the doctor, Dr Fine submitted it was important to promote responsibility in prisons and trusting patients with in possession medication was an important part of this. It was also part of the GMC's guidance as published in GMP. Whilst many prisoners exhibited difficult and challenging behaviour, Dr Fine felt it was even more important in these circumstances for a doctor to think carefully how to develop an appropriate and trusting relationship with the patient, but in both his interview and from his colleagues' comments it was evident this was not a concern for Dr Piyadasa.

2.13 Dr Fine commented further *(WS B3 T3 pp24-25)* that when the Acredita team had tried to explore Dr Piyadasa's attitude and consultation style during interview, he could only state that the problem was due to lack of time and pressure of work. On several occasions Dr Piyadasa interrupted and appeared not to be prepared to or able to listen to their questions, which then had to be repeated. He considered the conclusion in Dr Bicknell's report that the PCT should respond to concerns regarding Dr Piyadasa's administrative and communication skills, with a programme of mentorship and appraisal and opportunities for professional support through the PCT, local Deanery and Royal College of General Practitioners, echoed the conclusions and recommendations in the Acredita report.

2.14 At the hearing, Dr Fine submitted Dr Piyadasa's strategy to decline to describe a particular medicine and then refer the patient to the psychiatric in-reach team was unacceptable because of the delay that incurred with the risk of clinical deterioration and the possibility of self-harm or harm to others.

2.15 When asked what in particular had lead the Acredita team to the conclusion the principal problem was Dr Piyadasa's consultation style and communication skills, Dr Fine listed three things:

2.15.1 The interview they had held as a team with Dr Piyadasa's colleagues and other people at the prison. Comments were repeatedly made suggesting Dr Piyadasa had a brief consultation style, to the point he did not permit much time for the patient's viewpoint, and in terms of outcomes as reported in interviews, there tended to be a very brief instruction to the patient what to do, which did not permit any discussion or

disagreement from the patient, leading to a knock-on effect for the rest of the team.

2.15.2 The clinical records. Dr Fine was aware doctors could sometimes have lengthy, complex consultations with little written down, but he had got the very clear impression from the tone of the entries that there was no real discussion with patients why they disagreed with Dr Piyadasa or any attempt to reach common ground.

2.15.3 The interview they had held as a team with Dr Piyadasa. They were aware of the fact he must have been very anxious and nervous to face them although he did have a representative from the Medical Protection Society with him. They recognised he felt he had to work under pressure. However, they repeatedly had difficulty with Dr Piyadasa not listening to them or their questions and then answering questions not put to him. They were unable to cover much ground as they had to repeat their questions.

2.16 Dr Piyadasa's poor consultation style and communication skills would have an enormous impact on his clinical effectiveness; the ability to establish a trusting relationship with a patient and take a full and appropriate history was central to clinical practice, to avoid missing important or even crucial aspects of the patient's condition.

2.17 Dr Fine did consider it was highly inappropriate not to show Dr Piyadasa the 13 complaints upheld against him between January 2006 and March 2007. The Acredita team had looked through the complaints but they were very clear it was not part of their remit to investigate them so they did not pay them a great deal of attention, although they referred to them in their report, emphasising both Prison Management and the PCT should ensure a proper, robust system of complaints.

2.18 Dr Piyadasa's evidence was *(WS B3 T2 pp74-78)* that Nurse Boyce was only one of over 25 nurses at HMP Wandsworth who he only worked with minimally on reception as they were based on different wings. He categorically denied that he either routinely halved the medication for patients arriving at HMP Wandsworth or changed the medication itself, unless it was not available in the prison. He frequently contacted patients' GPs but only after surgery had finished. There was a difference between community and prison medicine; healthcare staff in prisons were more easily exploited and security could be compromised where healthcare staff became too personally involved with prisoners. He was not reluctant to conduct physical examinations of patients where required, but did not do so where it was not necessary and there was much greater pressure of time, for example, an inmate in the segregation unit requiring assessment before adjudication by the

Governor. He recalled that Nurse Boyce was often reluctant to help and accept his instructions.

2.19 Dr Piyadasa also submitted that he was never given the opportunity by either the prison or the PCT to respond to any of the prisoner complaints referred to by Mr Jamieson before they were upheld

2.20 He pointed out the views of another prison doctor expressed in interview notes that prison healthcare was challenging work, the prisoners were very demanding, they faked illnesses to avoid work or court and they did not come to see the doctors for chronic illness management.

2.21 He also contended *(WS B3 T3 pp94-96)* that Dr Fine's criticism of his relationship with patients seemed to suggest a lack of understanding by Dr Fine of the provision of healthcare in a secure environment. The patients he saw in prison were not a reflection of typical community practice and represented a challenging cohort, often with alcohol and drug abuse problems and mental health and personality disorder characteristics, who did not conform to norms of social behaviour. As a result, these patients might find it much more difficult to engage with their doctor, their perception was different to that of a community patient and they often felt that everyone in the prison, including the medical officers, were working against them.

2.22 Dr Piyadasa also pointed out that prison policy dictated that certain types of drugs could not be given in possession, such as Benzodiazepines or sleeping tablets. For drugs that could be prescribed in possession, the degree of risk was not an assessment that could be made by the doctor alone but was also for the wing staff, who would know the patient much better than the doctor. He was not aware that GMP dealt specifically with prescribing medication in a prison environment.

2.23 At the hearing Dr Piyadasa confirmed his position was that he would like to apply to the London Deanery for re-training and to work in a practice the PCT deemed suitable for however long it deemed necessary and on a salary suggested by the PCT.

2.24 He submitted that he was not told of any complaints before he was approached by Dr Finch and Mary Palmer from the PCT in early May 2007. When he asked for copies of the complaints they told him he would be given them in due course and to work normally in the meantime. They did not tell him what action the PCT would take and he had no further contact with the PCT before 1st July 2007 when he was suspended from the prison by Secure Healthcare without prior notice and with immediate effect and escorted from the prison. A disciplinary hearing scheduled for 12th December 2007 was adjourned and there had been no further hearing. He received a letter of dismissal from Secure Healthcare on 6th March 2008.

2.25 He undertook 10 full sessions per week until September 2005 when one of those sessions was reserved for CPD. Within each session he undertook 2 one-hour clinics seeing approximately 9-10 people per hour as well as any emergencies. There was supposed to be a triaging process before patients were put on the doctor's list but it never occurred.

2.26 Before clinic began Dr Piyadasa was allocated half an hour to check approximately 19 or 20 prisoners in the Care and Segregation Unit ("CSU") to ensure they were fit to face adjudication. Often the IMR was not available.

2.27 There were similar difficulties at the clinics; most prisoners did not have medical records or a GP in the community. They were the most deprived patients with drug and alcohol abuse and mental health issues, but they had had little care and attention in the community. Many were aggressive and abusive and would demand things as it was an area where they could exert some control because all other areas of prison were very strictly controlled. It was hard to explain the situation to patients; there were so many prison protocols e.g. what medication could be given in possession and how medication should be given.

2.28 On questioning, Dr Piyadasa confirmed he wanted to improve his consultation skills by working in the community. In response to the criticisms he had heard about himself he submitted he had been shocked by Nurse Boyce's comments and he had had no idea he was the source of most of the complaints or that he was different to any of the other doctors at the prison.

2.29 Dr Bicknell's evidence was *(WS B3 T5 pp114-116)* that prison medicine was one of the most challenging and difficult jobs in Primary Care. The recruitment and retention of prison doctors was a problem and unlike doctors in the community, prison doctors worked as employees of a PCT or a private provider, or they worked as locums, with a responsibility to their employers as well as their patients. They did not manage their own lists, the turnover of patients was high and providing continuity of care was especially difficult.

2.30 Within a prison, the issue of security was of paramount importance to the prison establishment. This had a huge impact on the way in which healthcare could be organised and delivered, with significant constraints placed upon healthcare professionals affecting prescribing, referrals, manual and computer records and the organisation of appointments.

2.31 The very nature of the patient group was of great significance in considering the work of a prison doctor. There was great ethnic diversity and patients showed a high incidence of substance misuse, mental illness and recidivism. Incarceration and institutionalisation

caused unique difficulties for prison doctors; there was typically another healthcare professional such as a healthcare assistant or nurse present at consultations, patients were not allowed to know the detail of their hospital appointments for security reasons, all prescriptions were provided privately, often placing extra pressure on the doctor to prescribe the least expensive treatments.

2.32 The concept of the healthcare provided in prison being identical to that in the community was flawed. Prison Medical Officers often adopted an approach of being firm but fair with their patients. In many establishments they were trained by prison security teams to ensure they were not conditioned by patients, to identify clear boundaries within the consultation and to avoid collusion. The doctor-patient relationship and the role of a prison doctor were very different to that of a community GP. Prison doctors were also expected to fulfil a security role within the prison in assessing patients held on the segregation unit or facing judicial procedures such as adjudication.

2.33 Dr Bicknell submitted there was absolutely no evidence that Dr Piyadasa's consultation style or prescribing affected patient care and, in his opinion, was entirely consistent with how competent prison doctors work within their establishments.

2.34 At the hearing Dr Bicknell submitted complaints about prison doctors were very common and totally different to complaints within the community. Prisoners were given complaint forms which were not part of the NHS complaints procedure; they typically complained after being refused something and were highly attuned to seeking legal or institutional redress for a perceived inequality. Prison doctors did not always see complaints; they were often processed in house and only passed on to the doctor if a specific medical issue had arisen, so e.g. complaints relating to a doctor's refusal of flat location or own clothing would be dealt with by the system and without reference to the doctor.

2.35 He felt that if the PCT was troubled by Dr Piyadasa's consultation style and communication skills it should be dealt with by mentorship and appraisal rather than contingent removal.

2.36 The fundamental issue for Dr Bicknell was the difference between a primary care consultation in the community with a registered patient, and the prison context, where neither the doctor nor the patient had any choice whatsoever. Whilst he agreed developing trust in the community context was very central, in the prison context trust could be forced and artificial and the concept of continuity of care and determining the patient's unmet needs was very different. Working in the prison environment was never an excuse for falling below the standards of good clinical care and prisoners were entitled to the same quality of care as someone in the community, but they often did not receive it. The prison system did not have any of the advantages of the

community system such as computer systems or QOFs; its tools and resources were sub optimal.

2.37 Dr Bicknell was unable to see a lack of efficiency from a clinical perspective; the fact there were no demonstrable adverse outcomes was very helpful reassurance of this doctor's safety in practising as a prison doctor.

2.38 His comparison between prison and community practice was based on his experience and Dr Piyadasa's clinical entries

2.39 It was unfortunate Dr Piyadasa had been stopped from practising at the time but a programme of appraisal, re-training, mentorship and support seemed reasonable, appropriate and entirely acceptable given his length of absence from practising. At the time mentorship and appraisal would have been sufficient but now the idea of re-training seemed very sensible and essential and he would support it.

2.40 Dr Bicknell considered that without such training Dr Piyadasa would still be safe to practice in a secure environment setting, but the nature of generic general practice training presented real dilemmas and he would need additional training if he was to work in a community general practice.

2.41 In closing, Counsel for the PCT submitted the number one focus of the Acredita report and the PCT were the deficiencies of Dr Piyadasa in relation to communication skills and consultation style. The evidence of individuals from many aspects of prison life (i.e. Dr Baikie, Nurse Lynch, Mr Constable and Mr Jamieson) who had worked with Dr Piyadasa over a considerable period of time and who understood the difficulties with an offender population related to examples of his communication difficulties impairing the care being provided.

3. Written communication/Handwriting

3.1 Having reviewed the 38 sets of medical records written in by Dr Piyadasa, the Acredita report identified a major problem in the legibility of his handwriting. *(B2 T4 p57).* All medical records at HMP Wandsworth were handwritten and there was no computerised record system either for clinical work or for audit and care management purposes. It therefore considered legibility assumed an even greater importance than in systems that relied on computer records. In addition, the Acredita team had seen evidence provided by Dr Piyadasa demonstrating that he was capable of writing very clearly and legibly. It found examples in 18 sets of records where Dr Piyadasa's handwriting was poor and at times undecipherable and examples in a further 18 sets of records where his entries were only partly legible and could not stand alone, often requiring cross referencing with other entries, although his handwriting was acceptable in 2 of those records.

In addition, 3 patients had drug charts with entries by Dr Piyadasa of unacceptable legibility.

3.2 Dr Baikie in his witness statement *(WS B3 T8 p50)* submitted that problems were caused by Dr Piyadasa's handwriting but although it was poor he was generally able to read it, perhaps because he was used to it. However, he was aware that other people found it extremely difficult to read, although he did not recall any problem with the content of his notes.

3.3 At the hearing he reiterated that he did not have any problems with Dr Piyadasa's handwriting.

3.4 Nurse Lynch submitted *(WS B3 T9 p53)* that she found Dr Piyadasa's handwriting difficult to read and that it caused problems generally on the ward, especially when trying to read the drugs chart. At the hearing she reiterated that his handwriting was very difficult to read.

3.5 Geraldine Blache confirmed that when she had interviewed Nurse Lynch she had said Dr Piyadasa's handwriting was frequently a problem. However, she also acknowledged that when she had interviewed Dr Nevin-Selvadurai (a long-term prison locum doctor), he had said that Dr Piyadasa's handwriting was not grossly bad, he could still read it and it did not interfere with patient care.

3.6 Dr Fine submitted *(WS B3 T3 pp25-26)* that he found many of Dr Piyadasa's handwritten notes to be illegible and others required significant time and effort to decipher. He considered that in an environment where medical staff were very busy, working under pressure and with little time, it was extremely unhelpful for a doctor to write in this way. It potentially led to problems in continuity of care between different clinicians and carried potential risks to the safety of health care for the patient. The importance of clear, legible and comprehensive clinical records was highlighted in GMP. He considered that even where handwriting was legible with significant effort on the reader's part, patient care was compromised by the impact on the efficiency of the healthcare service even if it did not necessarily represent a significant risk to patient health. Although the Acredita team did not identify any examples where the health of patients had been seriously harmed as a result of Dr Piyadasa's poor handwriting, the risk of such an adverse outcome was always present.

3.7 At the hearing Dr Fine confirmed he had looked at Dr Piyadasa's entries in the records on several occasions when he had managed to read a bit more. When asked to read the entries in three examples in the records he struggled and was unable to read them properly.

3.8 His concern was for the huge potential for error; it only took one error in reading a prescription and prescribing for there to be major

problems. The illegibility around Dr Piyadasa's prescribing was not acceptable and indefensible.

3.9 Dr Piyadasa could have written in block capitals, particularly for prescriptions. The Acredita team had evidence from their interview with Dr Piyadasa that he was capable of writing clearly.

3.10 Dr Piyadasa accepted *(WS B3 T2 p71)* that under stress and pressure, the standard of his handwriting might deteriorate. He did not believe this had ever endangered patient safety and it was only very rarely indeed, if ever, that any of his colleagues required assistance in understanding his entries in the records.

3.11 At the hearing he said that no one had ever complained about his handwriting or told him it needed to improve. The Prison Formulary had never returned one of his prescriptions with a sticker on it to say they could not understand his handwriting.

3.12 Both Dr Baikie and Dr Selvadurai accepted his handwriting did not cause them problems but he accepted that in another setting another doctor or healthcare professional might need to read his notes.

3.13 Dr Bicknell submitted *(B3 T4 pp110-111)* that the vast majority of Dr Piyadasa's entries were clearly legible to him on first inspection of photocopies. He also contended *(B3 T5 p116)* that all but one of the prescriptions on the drug charts were clearly legible and in keeping with the handwriting of a significant number of doctors. Some of the prescriptions were of a higher standard than he received from hospital prescribers on a daily basis.

3.14 At the hearing he reiterated that 95% of Dr Piyadasa's entries were clearly legible. He accepted a lesser percentage of lay people would find them legible but pointed out only medically trained people in prison had access to medical records, although he accepted some might struggle with some words and abbreviations. However, it was a fact that some of his very respected colleagues made appalling entries

3.15 In closing, Counsel for the PCT submitted that the panel would make its own evaluation of legibility but they should bear in mind that Dr Piyadasa's colleagues "groaned" about his handwriting. Legibility was not a requirement of superficial attractiveness but of importance to a wide range of individuals (e.g. healthcare officers, nurses and not just other doctors) who would need to read these records. The high turnover of patients and the frequent turnover of prisoners meant the records would be seen by new doctors in new environments very frequently. Furthermore, emergency situations were likely to arise in the prison environment when struggling to read notes would expose the patient to risk.

4. Continuing Professional Development (CPD) and identifying personal learning needs

4.1 The Acredita report identified a problem with Dr Piyadasa's CPD *(B2 T4 p67-70).* It pointed out that one session per week for CPD was included in Dr Piyadasa's contract, but having interviewed Dr Piyadasa the Acredita team concluded her did not take advantage of this session. His workload meant he had very little time at all in his working life for matters of professional development. He did refer to reading the "GP" newspapers – some being of more robust quality than others, but little was mentioned about reading, learning from and then application to practice of anything from quality (i.e. peer-reviewed) journals, or indeed anything from lesser quality publications, such as "GP" and "Pulse". If such reading had taken place, the Acredita team had little confidence that any application of this had occurred within Dr Piyadasa's practice within the prison.

4.2 Focussing upon Dr Piyadasa's clinical records and other matters left the Acredita team little time in which to investigate Dr Piyadasa's process for assessing his own learning needs and then meeting these. This was important given the lack of formal appraisal or other feedback to Dr Piyadasa. They felt his response to this question was rather disappointing and puzzling; silence followed by a suggestion that he might like to do more learning in relation to genito-urinary medicine.

4.3 The Acredita team noted two opportunities presented themselves to Dr Piyadasa for informal professional development. They were sharing an office with his colleague Dr Baikie who had on previous occasions opened up discussions relating to modern models of consultation skills and the opportunities presented through the recently instigated clinical meetings. Neither of these opportunities was taken and the Acredita team found this failure to take opportunities presented, together with Dr Piyadasa's apparent inability to identify, or to seek help in identifying, his own learning needs of deep concern.

4.4 They felt it was essential that, as with all other healthcare staff, all doctors working at HMP Wandsworth were supported in negotiating professional development opportunities. Although this was a professional responsibility of each individual health professional, it was also a responsibility of the PCT, as employer, and Secure Healthcare as manager, to ensure such professional development took place and that health professionals were given sufficient time for their personal learning and development needs. They also felt that the PCT and prison healthcare management must have clear arrangements in place to ensure that all doctors had an annual appraisal, and a rolling development plan in relation to their continuing educational needs.

4.5 Dr Baikie submitted at the appeal that although he was senior doctor at HMP Wandsworth, CPD was not his responsibility and every doctor was supposed to look after his own CPD.

4.6 Dr Fine submitted *(WS B3 T3 pp24-25)* that when the Acredita team asked Dr Piyadasa what his learning needs were and they took time to explain what they meant by this, he finally said he would like to learn more about genito-urinary medicine, which did not relate to his personal professional practice needs. He was unable to identify any other areas of clinical learning needs and appeared to have no insight into his own professional practice in terms of possible areas of weakness and/or areas where he needed to update his knowledge.

4.7 At the hearing, having seen additional evidence of CPD supplied by Dr Piyadasa, Dr Fine agreed that the if Dr Piyadasa had attended the courses and educational events indicated (there were no Certificates of Attendance for the majority of them), they were of a high quality appropriate to his practice. If he had attended the course on appraisal at HMP Holloway in 2005, he should have known at that point the purpose and importance of annual appraisal and ensured he fulfilled this contractual obligation for all GPs.

4.8 However, Dr Fine felt Dr Piyadasa's approach to CPD was extremely limited. The Acredita team felt he did have a responsibility, shared with other members of the healthcare team and the management of healthcare within the prison, to undertake CPD.

4.9 He submitted a doctor has always had a responsibility for his own professional practice, including keeping up to date and part of that was through appraisal. The PCT had a responsibility to ensure all doctors on its Performers List had appraisals.

4.10 The Acredita team had noted Dr Piyadasa's heavy workload and felt the healthcare provider was at fault in arranging things so the doctors had insufficient time for CPD but they also felt the doctors had to take responsibility for ensuring they had enough time to undertake CPD.

4.11 Dr Piyadasa submitted *(WS B3 T2 pp63-64)* that although no official opportunity for CPD was offered to him while he was working at HMP Wandsworth, he frequently attended meetings independently, out of hours, to further his CPD record. He attended drug company sponsored seminars and the bi-annual PRI-MED seminar, attended by over 1,000 GPs. He also went to postgraduate meetings at St George's Hospital and a monthly GP meeting run by the PCT. He kept a detailed diary of his attendance at CPD events, but he had not been allowed to collect this or his CPD record or certificates of attendance from HMP Wandsworth. He had supplemented his CPD with reading publications, in particular the weekly publications PULSE and GP, and monthly journals including Update, Practitioner and Prescriber.

4.12 He further submitted *(WS B3 T3 p99)* that under his initial contract with the PCT of 10 sessions per week, there was no provision for CPD. He fought hard to reduce the sessions to the approved 8 sessions per week recommended by the BMA. After three years, the sessions were reduced to allow for 1 CPD session, but no structured arrangements were put in place. He raised this many times with Dr Baikie, but to no effect.

4.13 At the hearing Dr Piyadasa provided some additional documentary evidence of his CPD which he had only been permitted to collect from HMP Wandsworth just prior to the hearing, but he submitted much of this evidence was missing, including all educational material since 2003 and all his GP magazines, journals, tear outs and reports of meetings he had attended like the GP forum and his 2007 diary.

4.14 He had not engaged in any CPD since he had been suspended, although he still subscribed to GP magazine and The Practitioner. He had not attended any courses because of the expense.

4.15 As Dr Piyadasa had been asked to work 10 sessions per week from 2003 with no time allotted to CPD, he undertook CPD on his own at weekends and day courses twice a year. He also attended evening and weekend meetings in his own time.

4.16 Not a single doctor had been appraised in prison between 2003 and 2007. He had fought for appraisal, going to a meeting at HMP Holloway and telling them the importance of being appraised by someone with prison experience and he had said he would be happy to help as an appraiser.

4.17 When asked, Dr Piyadasa confirmed he was aware of the NHS appraisal website and toolkit but he had not registered with it.

4.18 In closing, Counsel for the PCT submitted that particular anxieties for the PCT that emerged initially and over the course of the hearing, were:

4.18.1 the extent to which Dr Piyadasa had insight into his deficiencies and his need for training

4.18.2 the extent to which Dr Piyadasa was able to identify a piece of training he had undertaken which had then altered his practice

4.18.3 the extent to which, even today, Dr Piyadasa understood what appraisal involved

4.18.4 the extent to which, even now, Dr Piyadasa was able to accept there were deficiencies that needed to be addressed that did not simply arise out of his having been out of practice for two years.

4.19 Counsel submitted that Dr Piyadasa not having been in practice since July 2007 and having set himself on the task of returning to practice, it must be asked what he had done to improve his knowledge, skills and attitude during that period. It was disappointing he had done so little and he had evinced such startling gaps in his knowledge about contemporary practice.

4.20 Counsel for Dr Piyadasa submitted that the PCT had made no findings in respect of the allegations regarding CPD/identifying personal learning needs.

(v) Consideration and Conclusions

1. Preliminary point

We are aware that the 40 medical records which Dr Fine was asked to review were not randomly selected, as the PCT had thought, but that 10 of them were targeted, i.e. they came from a small pool of patients who had complained about Dr Piyadasa. We note that Counsel for Dr Piyadasa has contended the targeting of such a significant proportion of the notes from patients who had complained about Dr Piyadasa undermined the integrity of the review and was unfair, as was the fact that at no stage prior to or during the first PCT hearing was Dr Piyadasa given the opportunity to respond to the complaints against him or to consider the medical records on which the Acredita report was based. We have borne this in mind in considering the evidence and in reaching our conclusions.

2. Clinical knowledge and care

2.1 We first considered whether Dr Piyadasa's clinical knowledge and care were an issue that needed to be addressed. We noted the finding in the Acredita report that the evidence suggested that there were no noteworthy problems with clinical knowledge, but on occasions, a lack of time given to the patient prevented complete and adequate management of the clinical problem.

2.2 Our own view, having read and heard a considerable amount of evidence and having carefully reviewed the examples provided of Dr Piyadasa's clinical knowledge and care, was that whilst there were certainly some examples of poor and even bad practice, there were no examples of dangerous practice.

2.3 For example, with patient 6457, although there was no written evidence that a comprehensive history was taken, and when asked how another doctor would be able to evaluate how this patient was doing on the prescribed medication on the strength of his entry in the notes, Dr Piyadasa was only able to give the ineffectual reply that the doctor would have to ask the patient how he was doing, we none the less

considered that given the constraints of the prison environment and the abuse to which he was subjected by this patient, Dr Piyadasa's care for this patient, which ensured there was some follow up, whilst not ideal, was acceptable within such an inhibiting environment

2.4 Likewise, with patient 5227, the medical member of our panel concurred with Dr Bicknell that Dr Piyadasa's review of this patient was aimed at cholesterol rather than creatinine level. No harm was caused to the patient and it was unlikely that even if there was any impairment, his renal function would have changed or deteriorated in that time. We consider the fact this patient was not followed up after six months was poor practice but there was no indication Dr Piyadasa was intending to review this patient himself; he was another doctor's patient and although there should have been a CDM process in place at HMP Wandsworth, we did not hear sufficient evidence of how CDM in the complex prison environment should work to consider this as a major criticism against Dr Piyadasa.

2.5 Looking at all the examples of clinical care we were presented with, and in the absence of many of the medical records on which the Acredita report was based, whilst we considered many of the consultations fell well short of good clinical standards, we concurred with the PCT there were no serious or urgent situations requiring redress. That is not to say that we would not have concerns about Dr Piyadasa's clinical standards and unrefined approach in a community setting, but that we found them to be just about acceptable within a custodial or secure environment. We note that this is not a contentious issue and that Dr Piyadasa recognises his own shortcomings in this regard and the need to address them by way of re-training.

2.6 As the Acredita team, quite properly, did not approach their investigation in terms of producing evidence for any form of disciplinary hearing, the evidential base for some of their adverse conclusions was too narrow to withstand serious challenge, particularly in respect of the difficulties caused by the constraints of the prison environment. Whilst we note that the Acredita team did acknowledge that some of the responsibility for the problems which arose must also be borne by the PCT and Secure Healthcare, we would go further and state unequivocally that we consider the administrative and institutional shortcomings at HMP Wandsworth were at least as much to blame for the standard of clinical care there as were the personal shortcomings of Dr Piyadasa.

3. <u>Consultation style and communication skills</u>.

3.1 We went on to consider the issue of Dr Piyadasa's consultation style and communication skills. We noted the closing submission of Counsel for the PCT that this issue was the main focus of the Acredita report and that individuals who worked at HMP Wandsworth with Dr Piyadasa, including Dr Baikie, Nurse Lynch, Mr Jamieson and Mr

Constable (i.e. individuals from many aspects of prison life who understood the difficulties doctors faced with an offender population), had all given examples of Dr Piyadasa's communication difficulties impairing the care being provided.

3.2 Examples were given of Dr Piyadasa's refusal to explain why he would not prescribe a medication or why he was reducing the dosage, and the consequences which flowed from that, such as prisoners becoming aggressive, which unsettled the wing.

3.3 Other examples related to Dr Piyadasa's failure to communicate why he would not prescribe medication in possession (see patients 5334 and 4413 above) or refer them for an x-ray (see Peter Constable's evidence above).

3.4 Against this, we noted the evidence of Dr Piyadasa and Dr Bicknell. Dr Piyadasa contended that Dr Fine's criticism of his relationship with patients seemed to suggest a lack of understanding of the provision of healthcare in a secure environment. He explained the patients he saw in prison were not a reflection of typical community practice and represented a challenging cohort, often with alcohol and drug abuse problems and mental health and personality disorder characteristics, who did not conform to norms of social behaviour. As a result, these patients might find it much more difficult to engage with their doctor, their perception was different to that of a community patient and they often felt that everyone in the prison, including the medical officers, were working against them.

3.5 Dr Bicknell supported this explanation, contending that within a prison, the issue of security was of paramount importance to the prison establishment and this had a huge impact on the way in which healthcare could be organised and delivered, with significant constraints placed upon healthcare professionals affecting prescribing, referrals, manual and computer records and the organisation of appointments. He explained that the very nature of the patient group was of great significance in considering the work of a prison doctor, as patients showed a high incidence of substance misuse, mental illness, ethnic diversity and recidivism and that incarceration and institutionalisation caused unique difficulties for prison doctors; there was typically another healthcare professional such as a healthcare assistant or nurse present at consultations, patients were not allowed to know the detail of their hospital appointments for security reasons, all prescriptions were provided privately, often placing extra pressure on the doctor to prescribe the least expensive treatments. He explained that the concept of the healthcare provided in prison being identical to that in the community was flawed and that Prison Medical Officers often adopted an approach of being firm but fair with their patients. He pointed out that in many establishments they were trained by prison security teams to ensure they were not conditioned by patients, to identify clear boundaries within the consultation and to avoid

collusion. He emphasised that the doctor-patient relationship and the role of a prison doctor was very different to that of a community GP and that prison doctors were also expected to fulfil a security role within the prison in assessing patients held on the segregation unit or facing judicial procedures such as adjudication.

3.6 It seemed to us that many of the examples of issues which had arisen in relation to Dr Piyadasa's consultation style and communication skills, when opened up, were fair; indeed, the medical member of the panel was impressed with this aspect of Dr Piyadasa's work and he felt that Dr Piyadasa had made up his own mind in relation to these patients, often at the expense of his popularity. Popular doctors are not always the best doctors and we considered that Dr Piyadasa showed himself to be independent of thought and unwilling to be pressured into making the popular choice and that probity issues were more important to Dr Piyadasa than popularity. In her closing statement, Counsel for the PCT submitted that Dr Piyadasa distrusted rather than trusted his patients, but we considered it would have been irresponsible of him to trust all prisoners, given the problems of drug abuse and addiction rife in prison.

3.7 An example given of Dr Piyadasa's poor consultation style and communication skills was his refusal to refer to hospital the patient Peter Constable told us about. The medical member of our panel considered Dr Piyadasa's clinical refusal was appropriate and that he made a correct decision at the time despite being put under pressure by prison staff to do something, since a likely scenario was that the orthopaedic screws were beginning to cause inflammation of the jaw but were unlikely to have moved and in the absence of any further information regarding the screws, there was nothing wrong with what Dr Piyadasa decided. However, we acknowledged that a problem arose because Dr Piyadasa failed to explain why he was not prepared to take any action, with the result that he failed to be convincing to his own medical staff.

3.8 We considered that the Acredita team failed to give due weight to the very unique problems that healthcare professionals face in the prison environment. Whilst we accepted that Dr Piyadasa's communication skills and consultation style were poor and fell below an acceptable standard even within the prison environment and would certainly not be acceptable in community practice, we considered it was unrealistic to fail to take account of the distinction between practice in the community and practice within a secure environment. That is not to say that we considered working in the prison environment is an excuse for falling below the standards of good clinical care, or that prisoners are not entitled to the same quality of care as someone in the community, but that the reality of the situation meant that the prison system does not enjoy many of the resources available to general practice within the community and allowance must be made for this.

3.9 However, notwithstanding the above, we did agree with everyone who gave evidence, including Dr Bicknell and Dr Piyadasa himself, that Dr Piyadasa is now in need of training to improve his consultation style and communication skills before he can return to practice in either setting.

4. <u>Written communication/Handwriting</u>

4.1 We noted Dr Baikie's evidence that although Dr Piyadasa's handwriting was poor, he did not recall any problem with the content of his notes and he was generally able to read it, perhaps because he was used to it, although he was aware that other people found it extremely difficult to read. We also noted that Dr Nevin had said that Dr Piyadasa's handwriting was not grossly bad and that he could still read it and it did not interfere with patient care

4.2 We further noted Dr Bicknell's evidence that the vast majority of Dr Piyadasa's entries were clearly legible to him on first inspection of photocopies and that he also contended that all but one of his prescriptions on the drug charts were clearly legible and in keeping with the handwriting of a significant number of doctors and that some of his prescriptions were of a higher standard than he received from hospital prescribers on a daily basis. He did accept a lesser percentage of lay people would find them legible but submitted only medically trained people in prison had access to medical records, although he accepted some might struggle with some words and abbreviations. He pointed out that some of his very respected colleagues made appalling entries

4.3 However, Dr Fine had submitted that he found many of Dr Piyadasa's handwritten notes to be illegible and others required significant time and effort to decipher. At the hearing, when asked to read the entries in three examples in the records he struggled and was unable to read them properly.

4.4 Furthermore, Nurse Lynch's evidence was that she found Dr Piyadasa's handwriting difficult to read and that it caused problems generally on the ward,especially when trying to read the drugs chart.

4.5 We noted that Dr Piyadasa accepted that under stress and pressure, the standard of his handwriting might deteriorate. However, he contended that he did not believe this had ever endangered patient safety and it was only very rarely indeed, if ever, that any of his colleagues required assistance in understanding his entries in the records. The Prison Formulary had never returned one of his prescriptions with a sticker on it to say they could not understand his handwriting.

4.6 We noted that whilst the other prison doctors had acknowledged Dr Piyadasa's handwriting did not cause them problems, Dr Piyadasa did acknowledge that in another setting another doctor or healthcare

professional might have difficulty reading his notes. From our own observation of examples of his handwriting we considered much of Dr Fine's criticism to be valid and accepted that in an environment where medical staff were very busy, working under pressure and with little time, it was extremely unhelpful for a doctor to write in this way and that potentially it could lead to problems in continuity of care between different clinicians and carried potential risks to the safety of health care for the patient. Dr Fine had pointed out that the importance of clear, legible and comprehensive clinical records was highlighted in GMP and he considered that even where handwriting was legible with significant effort on the reader's part, patient care was compromised by the impact on the efficiency of the healthcare service even if it did not necessarily represent a significant risk to patient health. Although the Acredita team did not identify any examples where the health of patients had been seriously harmed as a result of Dr Piyadasa's poor handwriting, we accepted that the risk of such an adverse outcome was always present and we did consider there could be a significant problem if, for example, as happens frequently within the prison system, a prisoner was transferred elsewhere and healthcare professionals unfamiliar with Dr Piyadasa's handwriting needed to decipher a patient's records, or a patient could be placed at risk if someone was struggling to read the notes in an emergency situation.

4.7 However, we do wish to emphasise that we considered there was also an institutional failure in so far as there was no computerised system. In an environment such as this, we considered this was a highly unsatisfactory state of affairs.

5. Continuing Professional Development (CPD) and identifying personal learning needs

5.1 We noted the closing submissions made by Counsel for the PCT summing up the PCT's anxieties relating to Dr Piyadasa's CPD and the need for him to identify his personal learning needs, namely the extent to which Dr Piyadasa had insight into his deficiencies and the need for his retraining, the extent to which he was able to identify a piece of training he had undertaken which had then altered his practice and the extent to which, even now, Dr Piyadasa understood what appraisal involved and was able to accept there were deficiencies which needed to be addressed, which did not simply arise out of his having been out of practice for two years.

5.2 We further noted Counsel's submission that it was disappointing Dr Piyadasa had done so little since then and evinced such startling gaps in his knowledge of contemporary practice. Having been out of practice since July 2007 and having set himself on the task of returning to practice, Counsel submitted it should be asked what Dr Piyadasa had done to improve his knowledge, skills and attitude during that period.

5.3 Whilst we felt this was a valid question and that Dr Piyadasa must accept some responsibility for the deficiencies in his CPD and the lack of appraisal, we were also of the view that there had been an unfortunate combination of circumstances leading to a failure on both sides, and at all levels within the PCT and HMP Wandsworth. On being questioned, Dr Piyadasa submitted he became aware of the need for appraisal in 2004 and Tom Bolger (head of healthcare at HMP Wandsworth) told him the PCT was responsible for this, but it was not up to him to appoint an appraiser. He also told us he had fought for appraisal, going to a meeting on it in 2005 at HMP Holloway, where he had raised the importance of being appraised by someone with prison experience and he had said he would be happy to help as an appraiser.

5.4 We note that the PCT took no steps to monitor whether Dr Piyadasa was being appraised or to assist with this process, but we also consider Dr Piyadasa's own attempts at CPD and appraisal were feeble; he failed to demonstrate any knowledge of what is included within the appraisal process or of the NHS toolkit, which every doctor is encouraged to use. As Dr Fine had contended, if he had attended the course on appraisal at HMP Holloway, he should have known at that point the purpose and importance of annual appraisal and ensured he fulfilled this contractual obligation for all GPs.

5.5 Our overall impression was that Dr Piyadasa did not demonstrate any meaningful interest in or motivation for undertaking CPD. All PCT's ensure doctors on their Performers List have access to CPD via in-house training or PCT-run courses, but there was no evidence Dr Piyadasa had attempted to avail himself of the many and varied opportunities which exist to do CPD. He gave evidence that the PCT allocated one session per week to CPD in 2005 but he did not offer any evidence of what he did to make use of that, other than to say that no structured arrangements were put in place and that he raised this many times with Dr Baikie, but to no effect.

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5.6 Furthermore, whilst we were aware of the difficulties Dr Piyadasa faced in accessing documentary evidence of his CPD which he had left at HMP Wandsworth and his submission that much of this evidence was missing, we noted that he had not engaged in any CPD since he had been suspended, (although he attributed this to the expense).

(vi) <u>Findings</u>

1. Whilst being fully aware of the shortcomings of the PCT and the management at HMP Wandsworth as well as those of Dr Piyadasa in relation to this appeal, we have had regard to the fact that a significant degree of consensus emerged during the appeal as to the appropriate way forward and as to the suggested outcome.

2. Dr Piyadasa himself acknowledged that regardless of the rights and wrongs of how he came to be in his current position, he would benefit from retraining, having not practised since July 2007. He voluntarily agreed to, and undertook to abide by, conditions suggested by the PCT, (on the understanding that the PCT would honour its own obligations contained in the proposed conditions), save for the proposed condition that if he should not commence or complete retraining through the Deanery, he would voluntarily remove himself from the PCT's Performers List. He objected to this condition as he felt it would delegate to the GMC and the Deanery a decision on his future inclusion on the Performers List, before he had had the opportunity of establishing for himself what the Deanery's position or that of the GMC would be or whether there was any other solution should he not be accepted for retraining by the Deanery.

3. We note that he suggested instead that he should give the PCT notice immediately should he not be able to commence the Deanery training programme or should he leave that course, and that he would notify the PCT before seeking to work or obtain work as a GP, which would enable the PCT either to agree with him a further course of action, or in the event of a dispute, prevent him from working by removing him from the Performers List, even on an emergency basis pending a hearing, should it deem this appropriate. This appears to have been unacceptable to the PCT on grounds of cost (i.e. a further hearing (and possible appeal) would then be necessary and this hearing will have been in vain).

4. Counsel for Dr Piyadasa suggested that contingent removal was unnecessary and that the panel could make a decision on the basis of the undertakings provided by Dr Piyadasa being given both to the PCT and the panel. He also invited the panel to seek Dr Piyadasa's consent to any alterations or additions they might wish to make. His reasoning behind this suggestion was that the breach of any of the undertakings would be the breach of a promise given to the panel in that knowledge

5. We cannot accept this premise. We do not consider the Performers List Regulations permit an appeal panel to accept undertakings from a practitioner. In this regard we accept the submission of Counsel for the PCT that an undertaking has specific legal meaning, i.e. it is equivalent to an Order, but the only power the FHSAA has is that conferred on it by the statutory legislation, which is that it may make any decision on appeal which the PCT could have made.

6. From a practical point of view, whilst we consider that a PCT could enforce such an agreement for undertakings with a practitioner by initiating proceedings, we cannot see any way in which a FHSAA panel could enforce it. In any event, we note the PCT's refusal to accept undertakings being given in this way and we do not consider we have the power to force the PCT to accept undertakings it does not wish to accept. Counsel for Dr Piyadasa submitted the PCT acted

obstructively in objecting to his proposed course of action but we do not accept that to be the case. This is an efficiency case and unless we were to conclude that Dr Piyadasa does not need to be removed from the Performers List either contingently or at all, our decision needs to address the lack of efficiency by way of conditions

7. For all the reasons set out in the Consideration section above, our overall finding is that Dr Piyadasa's continued inclusion on the PCT's Performers List without being subject to any conditions would be prejudicial to the efficiency of the services in question.

8. We consider that contingent removal would be a proportionate response in the light of all of the evidence we have seen and heard. We have borne in mind that a significant degree of consensus emerged at the hearing as to the appropriate way forward and we have endeavoured to frame conditions to reflect this and also to cover the major sticking point of what should happen if Dr Piyadasa is unable to complete a Deanery Refresher Scheme.

9. Pursuant to Regulation 15(3) of the Performers Lists Regulations the Panel finds that Dr Piyadasa should be contingently removed from the Performers List subject to the following conditions:

(1). The Clinical Appraisal Lead of the PCT (or a suitable substitute nominated by the Lead) shall appraise Dr Piyadasa within two months of the date of this decision

(2) Dr Piyadasa shall submit a Personal Development Plan (PDP) to the Medical Director of the PCT within 14 days of his appraisal, to include the objectives identified in the appraisal and, in particular, development of his consultation skills and style, improvement in his handwritten entries in medical records, improvements in his record-keeping, and one session per week to be spent in CPD to address the learning needs identified in his appraisal

(3) Dr Piyadasa shall meet with the Medical Director (or a suitable substitute nominated by the Medical Director) within 14 days of submission of his PDP to discuss the PDP and for it to be approved, such approval not to be unreasonably withheld or delayed by the Medical Director (or his substitute)

(4) Dr Piyadasa shall undertake and successfully complete at the PCT's expense the GP Induction and Refresher Scheme provided by the London Deanery ("the Scheme"), or a suitable alternative as defined in (6) below, on the first available date offered by the London Deanery.

(5) Not later than 14 days after successful completion of the Scheme, Dr Piyadasa shall commence work for a period of six

months under supervision in a GP training practice allocated by the PCT ("Period of Supervised Practise"), while a GP supervisor at the practice ensures that the items in the PDP are completed and assesses Dr Piyadasa's performance against the PDP.

(6) If Dr Piyadasa is not accepted on the Scheme he should undergo training for twelve months in a GP Training Practice of no fewer than three principals allocated by the PCT ("Extended Period of Supervised Practise"), while a GP supervisor at the practice ensures that the items in the PDP are completed and assesses Dr Piyadasa's performance against the PDP

(7) Dr Piyadasa shall confine his practise within the National Health Service to undertaking either the Scheme and the Period of Supervised Practise, or the Extended Period of Supervised Practise, until they have been successfully completed

(8) Dr Piyadasa shall allow his GP supervisor to provide monthly progress reports to the PCT's Medical Director, either throughout the Scheme and the Period of Supervised Practise, or throughout the Extended Period of Supervised Practise.

(9) After completion of the Scheme and the Period of Supervised Practise, or after completion of the Extended Period of Supervised Practise, Dr Piyadasa shall meet with the Medical Director (or his nominated substitute) in order to arrange a further appraisal and to decide whether the objectives in his PDP have been satisfactorily fulfilled and to draw up a new PDP

10. The Panel requests the PCT to honour its provisional agreement with Dr Piyadasa that he shall accept the above conditions in return for a gross annual salary of not less than £50,000 ("the Salary"), payable monthly upon commencement of the Scheme or of the Extended Period of Supervised Practice until completion of either the Period of Supervised Practice or the Extended Period of Supervised Practise

11. The Panel requests the PCT to honour its provisional agreement with Dr Piyadasa to write to the GMC as soon as reasonably practicable, informing it of the above conditions, to state its opinion that this proposal will address both the concerns identified in the Acredita report and the need for Dr Piyadasa to refresh his general medical skills following a period out of work, and to request that the GMC lifts its interim suspension order and instead imposes interim conditions which mirror the above conditions.

12. The Panel reminds the PCT of its obligations to Dr Piyadasa under Regulation 15(4) of the Performers Lists Regulations.

(vii) Supplementary matters

1. Process leading to the appeal

1.1 Counsel for Dr Piyadasa submitted that Dr Piyadasa had a legitimate expectation that this panel would make some comment on the evidence it had heard and what this revealed about the investigatory process which led to and included the first PCT hearing in June 2008, which he maintained was fundamentally flawed and should have been dismissed by this panel as an abuse of process.

1.2 He also submitted the FHSAA panel should comment on the PCT's actions in order to illustrate the dangers of adopting a flawed approach to the investigation of GPs on performers lists (in the hope that similar mistakes may be avoided in the future).

1.3 In circumstances where the PCT had shared the Acredita report with both Dr Piyadasa's employers (against whom he was still involved in litigation) and the GMC (the report led to his suspension) Counsel further submitted it was only fair that the FHSAA panel note some of the evidence that it had the opportunity to hear which would otherwise not be public, in order to balance the impact of the Acredita report on Dr Piyadasa's reputation. In this regard he invited the panel to comment on:

- Appraisal
- Why was a hearing necessary at all
- The targeting of the medical records review
- The lack of availability of many of the medical notes on which the Acredita report was based
- The use of the Acredita report

1.4 Counsel for the PCT responded that the concept of legitimate expectation was a public law concept for use where a public authority has made a promise of a substantive benefit

1.5 She also contended that the correct practice was for the FHSAA panel to give reasons for its decision and that it did not have the power to make findings on process. The contention that the first PCT hearing in June 2008 should have been dismissed by the panel as an abuse of process was not applicable; this was a hearing de novo whereby anything which had happened previously was remedied and comment on process was beyond the panel's jurisdiction and irrelevant.

1.6 We consider it is appropriate for us to comment on some of the points raised by Counsel for Dr Piyadasa, not because of the concept of legitimate expectation, nor because we consider the FHSAA has power to make findings on process, but simply because we consider we are entitled to explain the context in which issues of fairness to the appellant were relevant to our consideration and conclusions.

1.7 In that regard we would comment that if what is alleged is true, Dr Piyadasa appears to have been treated unfairly by HMP Wandsworth. We agree with Dr Fine's view that it was highly inappropriate not to show Dr Piyadasa the 13 complaints upheld against him between January 2006 and March 2007 and to deny him the chance to respond to them. Both the prison management and the PCT should have had a proper, robust system for complaints in place.

1.8 We note the Acredita report was written on the basis it would form the basis of remedial action but consider Dr Piyadasa's suspension made any remedial action extremely problematic

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1.9 The targeting of the medical records review appears to have been an unhappy compromise between a proper statistically valid review of clinical effectiveness and care, and a review of matters subject to complaint. However, we accept this arose more through confusion than by design.

1.10 We do not consider we were constrained by the lack of availability of many of the medical notes on which the Acredita report was based since the appeal focussed on notes where medical records were available.

2. Other matters

2.1 The attention of both parties is hereby drawn to the provisions of Rule 43 of the Procedure Rules.

2.2 We direct that a copy of this decision be sent to the persons and bodies referred to in Rule 47(1) of the Procedure Rules**.**

2.3 Finally, in accordance with Rule 42(5) of the Rules, we hereby notify the parties that they have the right to appeal this decision under and by virtue of section 11 of the Tribunals and Inquiries Act 1992 by lodging notice of appeal in the Royal Courts of Justice, The Strand, London WC2A 2LL within 28 days from receipt of this decision.

Dated this day of 2009

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Debra R Shaw
Chairman of the Appeal Panel