Case No. 13847

THE FAMILY HEALTH SERVICE APPEALS AUTHORITY

Mr D Pratt – Chair
Dr J Lorimer - Professional Member
Mr W Nelson - Member

BETWEEN:

DR BHARAT BERRY
(GMC No. 2384441)

Appellant

-and-

WEST ESSEX PRIMARY CARE TRUST

Respondent

DECISION AND REASONS

THE APPEAL

1. This is an appeal by Dr Bharat Berry (Dr Berry) against a decision by West Essex Primary Care Trust (the PCT), communicated by its letter dated 7 June 2007, to remove him from its Performers List under Regulation 10 (4) (a) and (c) of the NHS (Performers List) Regulations 2004 ("the Regulations") [1]: these grounds for removal are known by the shorthand of "efficiency" and "unsuitability".
2. The appeal was heard over six days from 21 to 23 November 2007 and from 17 to 19 March 2008 at the hearing room of the General Chiropractic Council, Wicklow Street, London WC1X 9HL and (in part) at the NHS Litigation Authority, Napier House, High Holborn, London WC1V 6AZ. Dr Berry was represented by Mr Alan Jenkins, of Counsel, without solicitors, and the PCT by Mr Richard Booth of Counsel, instructed by RadcliffesLeBrasseur, solicitors. Following the conclusion of the hearing, both Counsel lodged written closing submissions on behalf of the parties.

DECISION

3. Our unanimous decision is to dismiss the appeal and direct the removal of Dr Berry's name from the Performers' List of this PCT.

REASONS

Background

4. There are matters which are not disputed between the parties. Dr Berry is a 54 year old General Practitioner who qualified in 1977. Since 1991 he has been in practice at Maynard Court, Waltham Abbey ("the practice"), and since 1992 in partnership with one other GP. Dr Berry is on this PCT's Performers' List and the practice is an NHS practice. It employs four receptionists and two secretaries, and in addition two part-time nurses and three nurse practitioners practise at the premises. Since 1996 Dr Berry has operated a slimming clinic from the practice premises each Monday evening, except that where a Bank Holiday falls on the Monday, the slimming clinic is held on a Tuesday evening. It is run on a private basis.

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[11] 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 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");
….
c) he is unsuitable to be included in that performers list ("an unsuitability case").

Patients paid £10 when they registered at the clinic and also paid £10 each time they received slimming drugs from the clinic. Patients who attended the clinic included some who were already NHS patients of Dr Berry and others who were patients on other doctors' lists elsewhere.

5. In April 2006 Dr Berry's practice was visited by the PCT's Director of Primary Care and its Medicines Management Advisor [see A 153 and following[2]] in connection with a proposed merger of practices. They sought information concerning the operation of the slimming clinic. Among other things they learned that Dr Berry habitually supplied to these patients two drugs which were controlled under Schedule 3 of the Misuse of Drugs Act, namely phentermine (also known by its commercial name of Ionamin) and diethylpropion (sometimes also known as Tenuate Dospan). These were not prescribable on the NHS and therefore not familiar to the PCT officers who were visiting. They made enquiries, and established that patients could become physically and psychologically dependent upon them and that withdrawal effect may occur if patients stopped taking them suddenly after several weeks of continuous use [A 154]. They were also informed that the Committee on Safety of Medicines and Medicines Control Agency had recommended in April 2000 that no further patients should be started on either of these drugs and they should be withdrawn from those currently taking them over a period of one to two weeks to reduce the risk of withdrawal symptoms. In fact, it later transpired that the drugs had been reinstated following an appeal from the manufactures and again withdrawn in May 2001, but reinstated in December 2002. This history of the drugs' status was not fully known to the PCT at that point. However, the PCT relies on the fact that, throughout the relevant period, neither drug was recommended in the British National Formulary (to which doctors may refer for guidance on drugs, their proper use, dosage and side-effects) or Royal College of Physicians or similar guidelines on obesity, because of concerns about dependence, side-effects on the central nervous system and lack of long-term safety and efficacy data compared to other products [see report of Professor Wilding A 232]. The PCT was also concerned about labelling and dispensing practices.
6. On 8 May 2006 the PCT received information from a nurse practitioner working at the practice (Sheila Byrne) that when she was working at the surgery on Tuesday 2 May 2006, the slimming clinic was operating but Dr Berry was not on the premises. She reported that a receptionist was seeing the slimming patients on her own and handing out slimming drugs.
7. An investigation was undertaken by the Essex Performance Advisory Group (PAG) on behalf of the PCT. On 19 May 2006, in aid of this investigation, the PCT obtained an ex parte Order from Mr Justice Jack in the Queens Bench Division of the High Court, prohibiting Dr Berry from destroying, removing or disposing of any evidence in relation to the operation of his slimming clinic [A 35-7]. The Order also obliged Dr Berry to disclose a list of all the patients whom he had treated with the two drugs phentermine and diethylpropion over the previous 3 years (separately listing his NHS and non-NHS patients), within 48hours of service. We understand this Order was served on 22 May 2006. On that date the PCT also hand delivered a letter from its Chief Executive informing Dr Berry that it was considering suspending him, and disclosing to him a copy of the PAG's interim report.
8. Up to this point in the chronology the issues with which we are concerned substantially concern Dr Berry's operation of the slimming clinic and management of his slimming patients. From this point in time a number of other issues arise, which may be described as issues of honesty and probity. Dr Berry's conduct during the PCT investigation and subsequently is said to have been dishonest, including destruction of record cards relating to patients who might not have been supportive of his case, falsifying records by adding to them before handing them over to the PCT, and seeking to influence evidence which might be given against him by employees or patients.
9. During the afternoon of 22 May Dr Berry paid a visit to the receptionist Donna Rule at her home. It is alleged he was agitated lest he be seen, and told her that they needed to get together in order to sort things out. At that meeting and during subsequent telephone calls it is alleged by Donna Rule that they would have to get their story straight, in particular to say that Dr Berry was always present at the slimming clinic. Her statement

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[2] References are to tbe document bundles listed and described at paragraph 31 of this decision

10. On 23 May 2006 Dr Berry wrote to the PCT [A 248 – 249] making representations about the allegations he had by now seen in the PAG interim report. Among other things he wrote:

    "I have never charged my NHS patients for consulting. This one-of [*sic*] £10 fee has always, certainly past few years been waived for them. I have only charged them for supplying the drugs Phentermine and Diethylpropion, from the belief that these were not available on the NHS, and made absolutely no charge when no drugs were given, only advice and discussion".

    "Naturally I am shocked and bemused by the claim that the receptionist has been dispensing these drugs. This has categorically never happened. She has once or twice in a blue moon given out these drugs at my request, as a prearranged thing between me and the client, whereby the client could only afford 1 weeks tablets and wanted to come back the following week just to pick up the 2nd weeks course of tablets…I have allowed Donna to give these out once I have given them to her beforehand, clearly marked treatment bottles for the named clients."

11. Christine Ford worked as a secretary within Dr Berry's practice. She had no medical qualification. A statement given by her to the PCT investigators [A 180 – 183] indicated that once or twice a week she was required by Dr Berry to go through a pile of prescriptions he had issued during the course of his surgery and imitate his signature on them because he had a problem with writing. She also forged his signature on death certificates on his instruction. She was instructed to put aside prescriptions for controlled drugs for him to sign personally. Sometimes she saw Dr Berry checking the prescriptions and sometimes she did not. She had instructions that if something was "odd" she should mention it to him. She took this to mean if something was wrong with the prescription. Dr Berry has undoubtedly been seen by a neurologist for a problem of writer's cramp [see medical correspondence at D 354 – 359]. He admits that he instructed Christine Ford to sign repeat prescriptions and death certificates as she describes.
12. It is common ground that on 23 May Dr Berry also asked Christine Ford to come into his surgery at the end of her normal working day and type two lists of patients which he dictated to her. The first was headed "23 May 2006 List of my NHS sliming patients and addresses past five years" and set out the names and addresses of 25 patients, and the other was headed "23 May 2006 list of non NHS slimming patients, Address and their GP (past five years)" and sets out 273 names, addresses and (in most but not all cases) the name of the patient's own GP. These appear at A 346 and A 347-352 respectively of the bundles. On the following day she was asked to type a supplementary list (A 353) of 5 patients whose names had been omitted from the previous list. Dr Berry was behind her as she typed, taking record cards in his hand and reading out the details. According to her statement Dr Berry appeared to be leaving some cards. It was impossible to say how many: it might have been four or five. This is not accepted by Dr Berry. Her unchallenged evidence is that Dr Berry left the surgery premises in possession of the printed lists and the record cards themselves.
13. On 24 May 2006 Dr Berry attended a hearing at which the PCT decided to suspend him. At that hearing he handed over a total of 302 sets of slimming clinic records.
14. On 16 June 2006 the PCT wrote to Dr Berry requesting further information [A 330-331] and he replied stating, among other things, "Last year, 2005, there was no occasion when the receptionist gave out drugs at my request", and "All the clinics in 2004 were done by me". Further information was sought, and at this stage Dr Berry obtained legal representation, as he was entitled to do. By a letter dated 31 August 2006 solicitors wrote on Dr Berry's behalf, saying among other things:

    "Dr Berry did not keep any diaries for his slimming clinic. Patients attended without appointments. It was the practice of the receptionist to maintain a diary for her own purposes. This continued until 2005. It did not continue in 2006. All previous diaries have been destroyed" [A299-303]

    It was repeated that Dr Berry ran the slimming clinic and "whenever he was absent the slimming clinic did not occur".
15. During the investigation the PCT obtained statements from staff and many of the slimming clinic patients. Donna Rule, the receptionist who helped Dr Berry to run the clinic from about October 2003, provided a statement [A 332-335] which alleged that Dr Berry had been

entirely absent from the slimming clinic about once a month, in which case she had been left to operate it on her own. These absences were when the clinic fell on a Tuesday, or when he had a tennis or social engagement. Sometimes he left the clinic in order to prepare his children's meal. When this happened she would weigh the patient, record it against the date she wrote on the patient's record and also the number of tablets she had given the patient. Dr Berry would have sorted out the medication in advance. She alleged that Dr Berry had been in frequent touch with her from 22 to 26 May but on that last occasion his manner was different and he had said words to the effect that she would be the one who would be in trouble if the PCT knew she had been alone in the slimming clinic when medication was given to patients. She also asserted in a further statement [A 336-337] that Dr Berry had told her he was going to send some records to the PCT but keep the rest. He asked her to go to his home to help sort out the records but she did not do so. He told her he wanted her help to remove the records of those patients who he was unsure would say what he wanted them to say about the slimming clinic. He was going to tell them to say that he was in the room or the building when they had been given tablets by Donna Rule. She said she had now looked at some record cards and some of the entries for patients' weight was in her writing, which only happened when she was doing the slimming clinic by herself, as otherwise Dr Berry would enter it.

16. The PAG produced its final report on 10 October 2006, in which it recited the evidence obtained and set out the detailed charges Dr Berry was to face. On the same date Dr Berry visited Donna Rule's home. She had just delivered a baby a few days earlier. Dr Berry brought flowers and offered his congratulations. He came in and sat on the sofa. So much is common ground. The rest is hotly contested. Donna Rule's further statement dated 12 October 2006 [C1228 -1229] asserts that her partner went out to take a telephone call, whereupon Dr Berry produced from an A4 sized book under his arm a typed statement and invited her to sign it. She read it quickly while holding her baby, but says she did not take it all in and just wanted to get rid of Dr Berry. However she knew that the letter was written as if from her to Dr Berry and that it said he had always been present at the slimming clinic and that she was never alone at the clinic. Despite knowing this was wrong, her statement says that she signed it as she did not want the aggravation of an argument. She telephoned an officer of the PCT to report what had happened and then made and signed the statement of 12 October [2 days after the visit] in which she retracted the contents of the letter she had signed. Dr Berry vigorously denies that any exchange of this sort occurred, and suggests that the [handwritten] letter signed by Donna Rule on 10 October is genuine and accurately reflects the facts.
17. Donna Rule made a further statement [C 1447-50] on 21 August 2007 in which she further alleged that Dr Berry had accosted her in her local Tesco branch towards the end of July 2007, called her a "traitor" and said words to the effect that if it had not been for her, he would not be in "this mess". Dr Berry's case is that this is an outright lie and the incident never happened. This statement also sets out in tabular form the entries on the patient records which Donna Rule said were in her own handwriting. There are 39 occasions on the cards she was shown, when her handwriting appeared other than simply writing in the headings. In addition the table mentions the name of patient SE, for whom there was no record of attendance between April 2001 and 20 March 2006, but whom she remembered seeing at the clinic in Dr Berry's absence on several occasions.
18. Having obtained the patient record cards handed over by Dr Berry (now said to be all that remained after he had "culled" many more from his records) the PCT obtained expert advice from Professor J P H Wilding, Consultant Physician in Diabetes, Endocrinology and General Medicine, with a special clinical and research interest in obesity since 1989. His report, dated 21 August 2006 [A 225 – 239], was critical of a number of aspects of Dr Berry's management of the slimming clinic, in particular the lack of any evidence of recording body mass index ("BMI"), taking a history or examining patients, and the practice of prescribing the drugs phentermine and diethylpropion to patients who were not overweight or obese, using them for longer than the recommended period, and continuing to prescribe them beyond the recommended maximum period of 3 months. He also concluded that there was little evidence that patients were warned of possible side effects (including potential dependence) before

they were first prescribed. His overall impression was that the clinic was operating simply to dispense these medications pretty much "on demand" with scant regard for the medical problems that can be associated with obesity. Professor Wilding considered this inconsistent with good medical practice and not in the best interests of the patients attending the slimming clinic.

19. In addition to the probity issues arising from Dr Berry's response to the investigation, the PCT (and subsequently this Panel) had to consider two other issues of impropriety:
    a. allegations that he had harassed a female patient (DL) who had recently been bereaved, by attending her place of work and inviting her out to dinner and using surgery records to telephone her at home, and subsequently by attending her place of work again to give her a letter of apology. A file note created by Karen Leese, a PCT officer [A 508], indicates that DL had contacted her to complain of this behaviour. This issue gave rise to some evidence before us about the provenance of a letter subsequently written by DL to Miss Leese (but delivered to Dr Berry) which said that her previous contact with the PCT had been misunderstood, that Dr Berry had never harassed her and that she did not want to be contacted any more. Dr Berry admits the attempt to set up a date, and the contacts he had with DL but characterises this is a brief lapse of judgement at a time of stress and which he brought to a swift end.
    b. Allegations of breach of confidence in disclosing in a social setting to a patient, Barry Shiakallis, information about other patients which was intimate in nature, including difficulties which another identified patient had had in conceiving. Again the evidence concerning the contacts between Dr Berry and Mr Shiakallis gave rise to subsidiary issues of how and where they holidayed in the same place on the Isle of Wight, such that one or other of them was not telling the truth.
20. During February 2007 the PCT conducted a hearing to determine whether to remove Dr Berry from its Performers' List and after its findings of fact were sent to the parties, received extensive written submissions. On 7 June 2007 it decided to remove Dr Berry's name from the Performers' List and its decision and reasons are to be found at C 1193-1194.

<u>The relevant legal framework</u>

21. This appeal is brought pursuant to Section 49M of the National Health Service Act 1977, as amended ("the 1977 Act") and regulation 15 of the Regulations, by virtue of which it proceeds by way of a redetermination of the PCT's decision, and this Panel may make any decision which the Primary Care Trust could have made.
22. Regulation 11 of the Regulations sets out the criteria for removal in cases of unsuitability and efficiency, and we have had regard to those and to the Department of Health Guidance, while not limiting our consideration of factors to those mentioned in the guidance, and we have considered all the factors urged on us in this appeal.
23. Regulation 12 gives us a discretion to remove Dr Berry contingently from the Performers List, subjecting him to conditions, but limited only to the case on efficiency: if we find him to be unsuitable, we have no discretion to remove contingently. Contingent removal requires that we impose such conditions as we may decide with a view to "removing any prejudice to the efficiency of the services in question": regulation 12 (2) (a).
24. In our view the burden of satisfying us that the case is proved, lies on the PCT, and we invited the PCT to lead its evidence first.
25. The standard of proof which we have applied is the balance of probabilities: whether a fact or allegation is more likely than not to have occurred. The panel recognises that some events are inherently more likely than others: as Lord Hoffman put it in *Sec of State for the Home Department –v- Rehman* [2001] UKHL 47:

    "It would need more cogent evidence to satisfy one that the creature seen walking in Regent's Park was more likely than not to have been a lioness than to be satisfied to the same standard of probability that it was an Alsatian. In this basis, cogent evidence is generally required to satisfy a civil tribunal that a person has been fraudulent or behaved in some other reprehensible manner. But the question is always whether the tribunal thinks it more probable than not".

When considering whether we are satisfied on a balance of probabilities that an allegation is established, we bear in mind that the more serious the allegation, the less likely it is that it occurred and the more persuasive should be the evidence before we conclude that the allegation is established.

Neither Counsel has contended that the criminal standard of proof should apply in this case or to the determination of any issue. However, we have also had regard to the guidance given by Holman J in *R (on the application of Dr Harish Doshi) v Southend on Sea PCT* [2007] EWHC 1361 Administrative Court in particular as to the practical application of a flexible approach to the civil standard, and the dicta of Lord Nicholls of Birkenhead *In re H (Minors)* [1996] AC 563 at pages 586-7:

> "Although the result is much the same, this does not mean that where a serious allegation is in issue the standard of proof requited is higher. It means only that the inherent probability or improbability of an event is itself a matter to be taken into account when weighing the probabilities…"

We understand our approach to be consistent with the decision of the House of Lords in *Re D* [2008] UKHL 33, decided since the conclusion of this hearing.

<u>Grounds of appeal, allegations and issues</u>

26. The notice of appeal, dated 3 July 2007, was prepared by Dr Berry's former solicitors and relies on broad grounds:
    (i) error in making adverse findings, without sufficient regard to the weaknesses in the PCT case or the case presented for Dr Berry;
    (ii) insufficient weight given to arguments for not removing Dr Berry from the Performers' List or alternatively for removing him contingently.
27. The PCT's grounds of opposition are set out in its letter of 2 August 2007, together with a bundle of supporting documents paginated R1 – 35.
28. We should say that we have excluded and paid no regard to the interim report, or to the final report, save to the extent that it is the document which sets out the charges relied upon, and when invited to do so we have also looked at the witness statements and other documents annexed to that final report. Otherwise both reports simply recite or paraphrase the primary evidence to which we have to have regard, or make provisional judgments on matters which it is for us to decide.
29. The PCT's allegations against Dr Berry are set out at pages A 132 – 144 of the documents bundles. We were told at the outset that the PCT did not pursue the allegations numbered xxii, and xlvii. The allegations may be considered under four broad headings, which are not mutually exclusive. We set them out below in a brief or paraphrased form, with the charge numbers in square brackets following. Where the allegations use the word "prescribed" we have considered that in the non-technical sense of supplying. We have of course considered the full wording in each case:
    a. Patient management;
        i. Failed to obtain and record Body Mass Index ("BMI") for 288 patients, as he should have done before prescribing slimming medication. [i]
        ii. Prescribed slimming medication to patients when it was inappropriate to do so by reason of their BMI (put simply, that they were not overweight or sufficiently overweight) [ii-xii], or without carrying out any appropriate examination [xv].
        iii. Charged NHS patients who attended his slimming clinic for medical examinations and medication when he was not permitted to do so [xiii-xiv].
        iv. Prescribed slimming medication to patients registered with other GPs without informing those GPs of the treatment he was providing to their patients, and/or advising patients he was expected to do so, or if they refused permission, recording that refusal. [xvi-xvii]
        v. Inappropriate use of drugs:
            - From 1995-April 2000, supplied Schedule 3 drugs to NHS patients privately, when they were available to be prescribed on the NHS, without so informing his patients [xix];

- Supplying phentermine and diethylpropion during other periods when either they had no licence or were not recommended by the Royal College of Physicians or the British National Formulary [xx-xxi];
- Dispensing drugs to NHS patients when his practice was not approved for dispensing [xxiii];
- Using medication inappropriately as a first line treatment for slimming patients without first taking a full history or giving lifestyle advice [xxiv].

vi. Failed, before supplying drugs, to:
- Take patients' blood pressure [xxv]
- Perform and record a physical examination [xxvii]
- Elicit whether the patient had any complications eg diabetes, sleep apnoea, nor test for diabetes or dyslipidaemia [xxviii]

vii. Management of patients on drugs:
- Issued medication irrespective of patient needs [xxx]
- Supplied slimming drugs for periods in excess of the recommended 3 months [xxxi];
- Failed to explain the side-effects and risks of the slimming drugs to patients, especially habit-forming properties, and therefore failed to obtain informed consent [xxxii];
- Failed to write on the bottle label the full name of the drug, the prescribed dose in words and figures and some occasions the patient's address [xxxiii]
- Persistently prescribed medication which he knew would create dependency [xxxv]
- Bullied patients into losing weight [xxix]

b. Management of the slimming clinic and staff.
   i. Required unqualified staff to supply Schedule 3 controlled drugs to patients contrary to the Misuse of Drugs Regulations 2001 [xviii].
   ii. Failed to record and store controlled drugs properly or to preserve records [xxxiv, xxxvi and xxxvii]
   iii. Required an employee, Christine Ford, to imitate his signature on prescriptions [xliii] and look out for any prescription that was "odd", thus indicating he had not personally checked the prescriptions [xliv]
   iv. Restricted patient access by failing to attend the slimming clinic on advertised dates [xlvi]

c. Patient confidentiality.
   i. Disclosing intimate clinical information about patients, in breach of patient confidentiality [xliii]

d. Honesty, probity and character of Dr Berry.
   i. Falsified patient records by entering blood pressures after the PCT had begin investigations [xxvi]
   ii. Destroyed patient records [xxxvii]
   iii. Falsely informed the PCT he had supplied all the slimming records which existed when he knew that was untrue [xxxviii]
   iv. Asked Donna Rule to supply false evidence [xxxix] and falsely informed her she was being investigated [xl].
   v. Harassed D L, a patient, by asking her on a date [xli].
   vi. Using Lloyd George record cards when he was not entitled [xlix] and claiming to own them when they were the property of the NHS [l]
   vii. Failing to co-operate with the PAG investigation [li]

Mr Booth on behalf of the PCT told us that the most serious allegations concerned the arrangements by which Dr Berry had allowed a receptionist, Donna Rule, to operate the private slimming clinic at times in his absence, including handing out drugs to patients.

30. Dr Berry's position, outlined in an opening statement, was that he was a highly regarded GP, who had never previously been the subject of complaint to the PCT or any other body.

Patients at his slimming clinic were properly assessed and treated. His position on supplying the drugs was: "It is denied that medications were provided other than with Dr Berry's express approval". No patient had been identified who said that drugs were given to them without Dr Berry's approval. The drugs provided were not inappropriate, nor given inappropriately or for longer periods than might have been correct. The storage of drugs and records was "acceptable". He contended that the drugs used by him were as safe as the alternatives suggested by Professor Wilding. If it were found that there were some patients where a prescription was inappropriate, they were few in number. His motives were always to achieve the best for his patients. Other allegations of impropriety were simply denied, and were characterised as "scraping the bottom of the barrel". The allegation concerning Mrs DL (the woman he had approached for a date) was broadly accepted, except that it was denied that there was any harassment.

Documents

31. The documents available to us at the outset of this appeal were contained within four bundles:

    Bundle A, pages 1 – 514: Report of the PCT's Performance Advisory Group (PAG) and appendices, which included witness statements;
    Bundle B – Dr Berry's slimming clinic patient records page 515 -1012;
    Bundle C – pages 1013 – 1464: including further slimming clinic patient records, further witness statements including that of Dr Berry, and correspondence;
    Bundle D pages 1 – 434 - the Appellant's documents.

    With our permission, the Appellant submitted a further bundle prior to the adjourned hearing of this case in March 2008, which was added to Bundle D as pages 435- 474.
32. The parties further submitted an agreed chronology at the outset. In addition we received during the course of the hearing a full colour copy of the patient records cards referred to at Bundles B and C above. Lastly, we were provided with copies of the GMC publication "Good Medical Practice" for the relevant period.
33. Certain documents or witness statements were excluded from consideration as evidence either by agreement or by way of our preliminary ruling. We excluded from our consideration both the PAG interim and final reports, except to admit and refer to the Schedule of Allegations [A 132 – 144] which contains the detailed charges faced by Dr Berry. Insofar as the reports recited or commented upon evidence from witnesses, our task was to evaluate that evidence for ourselves. The following documents which appeared in our bundles were excluded by agreement of the parties:

    Appendix 76 [A 513]
    Appendix 77 [A 514]
    PAG supplementary report and attached witness statements of Janice and Robert Hutton numbered Appendices 81 and 82 [C1208-1221] together with a PCT letter dated 6 February 2007 referring to that report [C1226-7]
    Appendix 8 [A 169] statement of Janice Hutton
    The documents at C1419 -1420

    In addition, we ruled that the following be excluded:

    Appendix 40 [A 338] statement of Jackie Whillock
    Appendix 66 [A 66] statement of Mrs Shiakallis
    Appendix 80 [A 514] statement of H Prentice
34. We were invited by Mr Jenkins to exclude evidence relating to charges which had not been found proved before the Panel of the PCT which heard the case below, but we rejected that application. The nature of this hearing is a redetermination of the case which Dr Berry faced below. We did not accept that it placed an unfair burden upon him. However the exclusion of the evidence we have set out above removed, in our judgment, the mischief which concerned Mr Jenkins.
35. We heard oral evidence from the following witnesses for the PCT (patient numbers correspond with the lists at A 346 – 353, where the prefix "N" indicates an NHS patient of Dr Berry, "P" indicates private patient and "M" a patient from the short list of "missed" patients):

    Janice Hutton - former practice manager
    Donna Rule - receptionist at surgery practice and slimming clinic

Barry Shiakallis - patient and sometime friend of Dr Berry
Hilary Todd - senior receptionist at the surgery practice
Christine Ford - secretary at the surgery practice
Karen Leese - PCT patient advice and liaison officer
Mrs CC - patient [not a slimming patient and therefore no number]
Mrs MG - patient P 106
Ms RW - patient M 4
Mrs VC (formerly VT) - patient P62
Mrs LK - patient P158
Ros Lock - Nurse practitioner
Shelagh Byrne - Nurse practitioner
Dr Richard Grew – GP and Clinical co-ordinator of PAG
Mary Tomkins - Pharmacist and Assistant Director of medicines management and PAG board member
Professor Wilding (expert diabetician and endocrinologist with special interest in slimming management)

36. We heard oral evidence from the following witnesses for Dr Berry:
    Ms DT – patient N 22
    Mrs JK – patient and mother of VK [patient N15]
    Mrs JN – patient N 17
    Mrs Chris Argyrou - clinical director of Paternoster House nursing home
    Miss VK – patient N 15
    Mrs DC – patient [not a slimming patient and therefore no patient number allocated]
    Mrs DP – patient [ditto]
    Mrs KR – patient [ditto]
    Mr C – patient and husband of Mrs DC
    Ms LP – patient N 19
    Mrs KB - patient P9
    Dr Bharat Berry - Appellant
    Dr Martin Shutkever - expert in General Practice
37. Where these witnesses were or had been patients of Dr Berry, in each case told us that they were content to be identified and to be asked questions about their health or dealings with Dr Berry. However for the purpose of this written decision we identify them as above.
38. At the conclusion of the evidence the Respondent put in 3 schedules (identified as R1 – R3). R1 listed agreed identification of handwriting in the slimming clinic records, R2 listed further identification of handwriting (not described as agreed) and R3 listed those patients who, it was contended were properly described as “low weight patients” on the basis of evidence heard or received by us.

Evidence for the PCT

39. The witness evidence was extensive, and we do not set it all out in detail.
40. We heard first from Janice Hutton, who had been Dr Berry’s Practice Manager. She adopted her statement which appears at A 169, in a redacted form, and a supplementary statement which appears at C1451-4. She is not medically qualified. She told us that she ran the slimming clinic from the late 1990’s until she left the practice in October 2003. She kept the diary in which appointments for the slimming clinic were recorded. It was in a drawer in the office in the reception area. She estimated that half to two thirds of the patients attending the slimming clinic had appointments, and the remainder were “walk-in” patients, who just waited to be seen. Ms Hutton then added their names to the diary. Each patient had a card [we saw many examples of these on what are conventionally called “Lloyd George” record cards]. She recognised an oblong box as one in which these cards were stored. She told us there were originally 3 such boxes which were whittled down to 2 boxes in due course. It was her duty to take these boxes of slimming cards into Dr Berry’s consultation room for slimming clinic sessions. She would write on the cards of patients who were attending “WT” for weight and “BP” for blood pressure. Dr Berry would write the actual figures next to these when he saw the patient. If it was a new patient she would write a heading with a health history for Dr Berry to complete.

41. Ms Hutton told us that there were occasions when Dr Berry was not present during the slimming clinic, when he was on holiday or had an appointment or when he had a tennis or cricket fixture or when he needed to be with his children. She estimated this was about 5 or 6 times a year but may have been more. Sometimes Dr Berry had to leave the clinic before it had finished and she then carried on by herself. When that happened she ran the clinic in the same way and filled in the cards herself. She would take the patients into Dr Berry's room, weigh them, given them their tablets and take the money from them. She would then record the tablets she had given out and the money she had taken. When dealing with patients on her own she would ask if they wanted the same tablets as they had had before. If they said they were not feeling well or wanted a change from the previous dosage she could not do that and told them they would have to see Dr Berry. A supply of tablets for either 1 or 2 weeks would normally be given. These were already made up in bottles labelled with a white sticker. These drugs were kept in Dr Berry's room, sometimes in a box like the record card boxes, in a cabinet which was generally locked, but sometimes in a drawer of his desk, which was sometimes locked and sometimes not. Ms Hutton had access to the key. She was involved in labelling the bottles of pills. On a plain white label she wrote "Ionamin 30 mg x 7 " or whatever was otherwise appropriate to identify the drug and number of days supply. She then stuck the label on the bottle. No other information (or patient name) appeared on the label.
42. Ms Hutton's supplementary statement identified some 41 substantive entries relating to weight, tablets given, or both, which were in her handwriting on the patient record cards. She was taken through those cards in her evidence, and the relevant patients were given numbers referenced to the list of patients who are listed at A 346 (25 "N" patients who were also on Dr Berry's NHS list and were) and A 347- 352 (273 private patients designated "P"). Among other things she told us that where she had written the patient's weight in figures, this meant that she had seen the patient on her own, as Dr Berry otherwise weighed the patient on the weighing machine in his room. The same was true of entries for the type and dosage of drugs, such as "Ion 30 x 14" [meaning 14 days' supply of Ionamin 30 mg tablets].
43. In relation to patient P 116 (page B843) the whole entry dated 16.7.01 was in her handwriting. Her attention was drawn to the recorded weight of 9 stone 8 lbs, and she said that she had no instructions as to when she should <u>not</u> give out tablets. She said it was Dr Berry's decision and "basically, if they came in and wanted them [pills], they would have them".
44. There were some entries on patient cards (for example P 37 on page B 678, and P 181 on page B 984) where there was a change of drug on an occasion when Ms Hutton had written the record in her own hand, but she said that these were occasions where Dr Berry would have authorised the change, because the patient was picking up her pills on a day other than the usual slimming clinic day, or before the patient attended.
45. She said she was never asked by Dr Berry to record a patient's height or measure their waist. Patient P 271 (page C 1166) had been seen by her on her own, on 1 October 2001, not having attended for 2 months before that. The patient collected 14 days supply of Ionamin tablets. However Ms Hutton said she had not been given any guidance on whether a patient should be reassessed after any particular gap in her attendance.
46. Ms Hutton told us that the numbers attending the slimming clinic on any particular day would vary from 7 or 8 up to 20 or 25 people. In all there were about 300 – 400 slimming patients. If a patient had not attended for about 12 months the record card was removed and stored in bundles in alphabetical order in Dr Berry's locked glass cabinet. When she left the practice there were definitely 2 boxes of record cards for current patients.
47. In cross examination Mrs Hutton agreed that Dr Berry desired to do the best for his patients. She agreed he was efficient but on the matter of his being anxious for staff not to spend time on the phone, she thought it inappropriate that he only allowed only one minute for each phone call, since that was not always possible with elderly patients, and made added pressure for staff, but she said staff accepted that that was just how he was. However he would always take a call from a slimming patient even it the surgery was busy. She said that while she would agree Dr Berry liked to be in control, she was critical of his handling of staff. An example of his capricious requirements was patient MR about whom she needed to speak to him at the end of his surgery while he was having a drink, but he required her to tell him what was the problem in no more than three words.

48. Mrs Hutton agreed that for the overwhelming majority of Monday slimming clinics, Dr Berry was in attendance, but continued to insist that on some occasions he was not, as described in her witness statement and evidence in chief. As for the record cards she said that those which were removed from the boxes of current patients because they had not attended the slimming clinic for years, were not thrown away but were stored in Dr Berry's cabinet. There were originally three boxes of current patients but the cards were then combined into two boxes. It was not suggested to her that this was incorrect.
49. Medication was stored in a similar box to the cards, sectioned in half, each containing one type of medication. Sometimes these drugs were kept in his cabinet and sometimes in his desk drawer. Sometimes she had locked this, but sometimes not. The key was kept in his cabinet or in another drawer of his desk to which she had access.
50. When a patient first attended the slimming clinic Mrs Hutton explained she would first put in the basic details on a record card, and the patient would then be seen by Dr Berry. She would not be present in the consulting room. She did no remember any dietary sheets being handed out to patients. An examination would take 10 – 15 minutes and Dr Berry would complete the other details on the card. She agreed he did sometimes use a red pen to indicate a particular problem, for example if the patient was pregnant, but did not agree that he sometimes drew a circle around a raised blood pressure reading.
51. Mrs Hutton was challenged about the reasons she had given for Dr Berry's absences from the clinic. It was suggested that Dr Berry did not play tennis on Mondays, but said in the summer months he possibly did or maybe he was playing cricket that day, as his absence was often for sporting commitments. There was also annual leave or his family situation. She remained clear that on 5 or 6 occasions a year he was not there at all, and at other times he left the clinic early because a sporting fixture was starting at around 7 pm. She agreed she could phone if she needed him but it was not always possible to reach him.
52. Mrs Hutton's attention was drawn to an entry in her handwriting on the record card of patient P182 [B986] for 31 March 2003, where, after entering a weight of 10 stone, she recorded "will speak to Dr B re changing tabs". It was put to her that this was an occasion when Dr Berry had left early and she had tried unsuccessfully to contact him. She acknowledged this was possible but she did not think it had happened here. She said that that was in line with her procedure. This request for a change of tablets was something the patient would have asked for, and she would not have made such a decision herself, as she did not know enough about the tablets and side effects: it was not within her knowledge or power. She did handle the clinic in his absence and understood it was OK to do so on his instruction. The only times she filled in the patient's record card herself were when Dr Berry was not there.
53. She was shown various patient record cards by Mr Jenkins. In relation to the entry on page C 1032 [patient P 204] on 27 May 2002 she was clear that Dr Berry could not have been there because she had written the weight and she would never do that if he was there. She explained that the weighing scales were in Dr Berry's room, and if he were present he would be in his own room and she would be on the reception desk. She was next shown another patient record card for 27 May 2002 [Patient 191, page B 1005] and agreed that this was in Dr Berry's handwriting. She agreed that he must therefore have been present for at least part of the clinic on that date. Some other record cards relating to the same date were examined. Patient 190 [B 1001] had had her weight recorded in Mrs Hutton's handwriting, but no blood pressure recorded. The patient received Ionamin tablets. She did not accept that Dr Berry had been present and told her the weight to write down on this card. She would have been elsewhere on reception. Patient 192 [B 1008] had had neither weight nor blood pressure recorded but had apparently received 7 days' supply of Ionamin tablets. She did not understand how no weight was recorded if the patient actually attended on that date.
54. In re-examination as to her authority to issue drugs, Mrs Hutton explained she would not give patients drugs on a first attendance, or if attending after a gap of more than 6 months, but if a patient who had been attending previously had been given slimming drugs, and said she would like some more, she would give them out "if I could see there was regular dispensing of those drugs and they were having no problems". She reiterated that there was never an occasion when she weighed patients in Dr Berry's room while he was present. As to the

attendance of patients P 190 – 192 on 27 May 2002 she said they were a mother and her two daughters and the date was a Monday.

55. Questioned by the Panel, Mrs Hutton explained that patients could arrive with or without an appointment. She treated Dr Berry's NHS patients in the same way as the private patients. If they were old patients they were usually in the consulting room for about 5 minutes. Normal consulting time in a non-slimming clinic was about 10 minutes. When patients came out of the consulting room they might be carrying medication or might come to her for it. If so she would decant pills from a big pot into little brown bottles and go in and hand over the tablets in between patients. It was all done "on my feet". She had no written instructions. Dr Berry did all the stock control for the drugs. Normally for the other drug requirements of the practice she was responsible for placing order, but not for the slimming clinic. Any medication left over at the end of the clinic was put back in his room, sometimes locked away and other times placed on top of his large double fronted glass cabinet until the next slimming clinic. Mrs Hutton told us that she simply responded to the requests of the patients unless there was an entry in red pen on the record card. Patients sometimes chatted to her about the effect of the pills. Some said "everything speeded up, I cant sleep". Asked further about this aspect by Mr Jenkins in due course, she said she advised these patients to tell the doctor but they said to her he told them it was "just the side effects of the tablets and that is what happens".
56. Mrs Hutton told us that some of the patients were actually quite slim but just wanted to stay slim. She sometimes commented to them that they had no need to be on the tablets, but she could only remember one patient, who was very very thin, to whom Dr Berry did not hand out drugs. If the clients returned to a subsequent clinic and she was on her own, she asked if there were any problems (although she was not specifically instructed to do so) and if they were happy on the drugs they had had, she would supply some more.
57. She was not aware of any patient who had had tablets stopped or reduced after seeing Dr Berry. The drugs were placed on top of his cabinet half the time. The boxes of cards were kept under his examination couch.
58. Donna Rule next gave evidence. She recognised and adopted her statements: A 332 – 337. She was normally a receptionist at the practice but after Jan Hutton left in October 2003 she took over the reception duties for the slimming clinic as well. It normally operated on a Monday evening from 6 until 7.30 pm, unless there was a Bank Holiday in which case it was on a Tuesday. If Dr Berry was not there, which she estimated was once a month or every 5 weeks, she ran the slimming clinic with nobody else to assist. She would explain to patients who attended that Dr Berry was absent and she could weigh them but not take their blood pressure, and could give them medication, if they were happy to go ahead she took them into Dr Berry's room and weighed them, and gave them their usual tablets unless they wanted to change them. She would not see new patients (who attended all the time, not always by appointment). For existing patients she knew what drugs to give them by what was on the card from the time before; normally it was a 2 week period. They paid £10 per week for the drugs or £20 for a fortnight, by cash. When she was handing out drugs she got them from a drawer in Dr Berry's room. She thought it had a lock but was not sure if it was in fact locked. The drugs were kept in little brown containers. She knew what they were by the colour of them: diethylpropion were big white ones and Ionamin 15 mg were grey and green and the 30 mg size were burgundy colour. She would automatically give them the same tablets as were previously recorded on the card, unless they said they were not agreeing with them and she then said they must see Dr Berry. Ms Rule said she had received no particular instructions about handing out medication, or how to assess the patients. She was not given any weight guidelines or told to measure height or waist.
59. She was aware of what they did by what the patients said: it made you high and you couldn't sleep and it gave you a buzz. She was not aware of side effects generally.
60. When Dr Berry was present she sat in reception and pulled out the patient's card on their arrival and wrote on it the date and the words or abbreviation for "weight" and "BP". Dr Berry would fill in the rest when he saw the patient. If she was on her own and the patient had not been in for a while, she would not give out drugs, but she had not been give instructions about the length of gap or how to react. Those who were his NHS patients paid like the rest

and she put the money in Dr Berry's desk drawer. There would be from 5 or 6 up to 20 sliming patients at each clinic.

61. On 22 May 2006 she had been aware that PCT had visited the practice and she referred to her statement at A 334 as a description of the events. At about 2.45 pm, as she was getting ready to go in to work, Dr Berry had come to her house that day and said "we need to talk". He said they needed to sort it out and get their story straight. Ms Rule said she had no clue what was going on. Dr Berry said "You need to be on my side, you need to say what I am saying". He did not say what it was that she should say at this time, because another employee rang to say that the PCT officers were waiting to see her at the practice and where was she. On a later date Dr Berry spoke to her and said she was in the wrong because she was the one giving out the slimming tablets not him. He telephoned her on a number of occasions over those days following 22 May and said he wanted Ms Rule to help him sieve through the boxes and whittle down the record cards to people he thought would be OK. He wanted her to go to his garage to do this. He also asked her not to mention that she had run the clinic on her own and to say Dr Berry was always in the vicinity. She remembered 3 boxes of record cards when she was last in the slimming clinic, which were kept in Dr Berry's room on the floor under a cabinet. There was only one now. She did not know what had happened to the other boxes.
62. Donna Rule then identified and adopted as true her third statement at pages C 1228-9 [see synopsis at paragraph 16 above]. She had had her baby two weeks earlier. She said the conversation became rather awkward and unnerving. In relation to what happened when her partner went out of the room to take a telephone call, she said that Dr Berry had written out a statement for her to sign and said "can you just read this quickly and sign it". Then he asked her to write it out herself and sign it. He then went to look where [her partner] was. She said "I just wanted to get him out of the house and I don't know what I was writing out and signing. I think it was to the PCT but I can't really remember". This letter appears at the Appellant's bundle, D 24. It is handwritten, dated 10 October 2006 and addressed "to whom it may concern". The material paragraph says:

    > "I was trained and supervised for this clinic by Dr Berry. I never gave out any Drugs or medications to the patients unless I was specifically asked to do so by Dr Berry while he was still doing the clinic or present in the surgery. I did not ever give the drugs out in his absence."

    After he had left and she told her partner what had happened he said she had done something really stupid and they had had a row. She then telephoned a PCT officer with whom she had had previous contact.
63. Donna Rule was then taken to her fourth statement [C 1447-50] which she confirmed as true, and she then described being in Tesco towards the end of July 2007 when she felt a tap on her shoulder and it was Dr Berry. She was shocked. He used the word "traitor" and said he could not believe she was doing this to him. She walked out and felt sick. She did not even buy the baby milk she had wanted. She spoke to a former colleague at the practice and was advised to contact police, which she did. They said they would talk to Dr Berry.
64. She was then taken to a number of original record cards on which she identified her handwriting. It is necessary to observe that it seemed to this Panel that the figures written by Donna Rule or Dr Berry were very similar in appearance, and it was not clear at a glance who had written what. Indeed Donna Rule was occasionally hesitant in identifying what was hers, and both Counsel later approached this on the basis that from time to time she had made mistakes; indeed Mr Jenkins submitted it was completely unreliable. Her evidence to us was:

    B 598 [patient KA] 21 November 2005 her writing for weight but not BP, which was in Dr Berry's writing.

    B 643 - weight in her writing but BP in Dr Berry's handwriting

Donna Rule commented on these entries that she would never have weighed a patient if Dr Berry was present and would never underline the weight as it was on the latter card. She could not understand how the blood pressure recording was noted by Dr Berry.

    B 646 [patient P22] entry for February 2005 all in her handwriting (including about previous operations) except for the word "paid" beside Registration Fee £10, the figures

"110/70" written next to BP and the abbreviation "C/I" . She commented she would never see a new patient.

B 767 [patient P81] 7 March 2003 (should be 2005) the abbreviations "WT" and "B/P" and she thought that the figures for weight were also written by her. The figures for B/P were in Dr Berry's hand (the same BP as both the previous attendances). The next dated entry, 4 April 2005, had a gap next to "B/P" and a weight entered

B 517 [a patient whose initials were SE, patient M1]: Donna Rule said that on 20 March 2006 the figures recording weight were in her writing but no other writing on that page was hers. However she said this patient was one she remembered well and she had seen her many times when Dr Berry was not present. 20 March 2006 was the first date on the only available record page. It did not indicate she had registered then. Ms Rule said she had not been absent from the clinic for a long gap before March 2006, and had attended regularly before that, so there should have been other record cards.

B 551 [patient N9] was in Ms Rule's handwriting below the line and the entry dated 25 July 2005 was all hers.

B 894 [patient 138] the entry for 9 August 2004 was all in her handwriting. The entry for 15 November 2005 was in her writing except the figures written next to "B/P". She repeated in relation to this date that if Dr Berry had been at the surgery she would not have written the weight on the record card.

For the sake of clarity we note here that this conundrum of Donna Rule recording the weight but the blood pressure being noted in Dr Berry's writing for attendances on the same date, was said by the PCT to be explained by Dr Berry having added blood pressure recordings (within a normal range) at a later date before he handed the record cards over to the PCT. This is denied by him.

65. Donna rule said that the dates when she had operated the clinic on her own were mainly in the summer because that was when Dr Berry might be on holiday or playing tennis or other engagements.
66. Mr Jenkins cross examined Donna Rule on behalf of Dr Berry. She said that they had got on well when they worked together. She liked the other girls working in the practice. She did not always like working for Dr Berry himself because he was a control freak. He let his feelings be known many not in a professional manner. She had volunteered to do the slimming clinic. If she had had concerns she would have spoken to the senior receptionist (there was no practice manager). But she had no reason to think things were untoward. She said that when a patient first attended she had instructions from Dr Berry to write up information for the initial examination, such as smoking and alcohol habits. She knew he took a history at the initial consultation to ensure it was safe for them to take the pills. On occasion he wrote something in red on the record card where there was a concern about the patient. She was never in the consultation room with Dr Berry herself, and could not therefore say what advice he gave about side effects.
67. There was a diary in which some patients booked appointments. If he knew a patient was coming back in two weeks Dr Berry might scribble an entry in the diary. She denied that the occasions when she handed out tablets in his absence were occasions when he had approved giving a patient her usual tablets if he had spoken to her on the telephone, although she agreed that might have happened occasionally. He did live a couple of minutes away by car, but if he left early, as he did, she was no given instructions to ring him if any patient came in, and she had never in fact rung him to say patient x had just come in to the clinic.
68. Donna Rule agreed that the average number of patients on any particular slimming clinic evening was around 15. Mr Jenkins put some arithmetic to her on the basis of this agreement, that if she had done the clinic on her own once a month over 2 ½ years, that meant there should be 450 entries solely in her handwriting. She said there may be 450 entries in her writing. There were more than 20. She disagreed with the case put to her that there may have been 1 or 2 occasions in the course of a year when Dr Berry left early but made it plain he wanted to be informed if more patients arrived. She thought it was not true to suggest that he was concerned to know about his patients if he was away. Nor was it true that he had left envelopes of tables for named patients.

69. It was put to her that she had grossly exaggerated the number of patients she saw on her own: she disagreed. She said she remembered seeing specific patients on her own, regularly. She had told Mr Greenwood (an officer of the PAG conducting the investigation) the names of these patients and he had made a list.
70. She was asked about Dr Berry's visit to her home on 22 May 2006 (the date on which the PCT served the legal documents at the surgery premises). It was not suggested to her that the visit never happened. She repeated her account in substance. He had not said there was a High Court order to draw up a list of names of those who had received drugs at the slimming clinic. Asked about the suggestion that she had been asked to go to his garage to sort through the records, she said she had never in fact been to his garage so did not know what was in it. She did repeat that he had said he needed to take out the ones which were not trustworthy.
71. As to the visit to her house in October 2006, she said she wrote and signed the document because she felt under pressure: her baby was just 2 weeks old and she "just wanted him gone". She agreed that in her statement she had said it was a typed letter which she just signed. However she said that in fact (as she told us in chief) she had copied it out at his request including any spelling mistakes there may be. She did not know what was in it. It was put to her that you cannot write something out without knowing what you are writing, but she responded "you can if you had a baby 2 weeks ago". She agreed that her partner is a sergeant in the police force and she therefore knew the significance of making a statement. She said she felt "under pressure big time" and could not wait to get Dr Berry out of the house. It was put to her that she was not telling the truth. She disagreed.
72. She was asked about the incident when she alleged Dr Berry had accosted her in Tesco. It was a Friday roughly 7 months ago. She referred to her statement about it. She had spoken to police at Central Station, Harlow, but had not gone in. She could not remember the name of the man she had spoken to. However she said she was contacted by another officer who told her they had spoken to Dr Berry. It was put to her that this was a complete fiction. She was asked to provide details of the person she spoke to and whether that officer was known to her partner, Steve. It was suggested to her that she had made up this lie to make things worse for Dr Berry. She denied it.
73. She was asked about the reason for Dr Berry's absence from the clinic, given in her statement on page A 332. She remained of the view that he did play tennis on Mondays and had not confused that with other nights. It was also suggested to her that, contrary to paragraph 21 of that statement, patients had not been on sliming pills for months and months and years. She said some such as SE had been on them for a lot longer than 3 months. She was also asked about her supplementary statement at C 1228 which is dated 12 October 2006 (before the February 2007 hearing held by the PCT to consider removal) but had not been disclosed for that hearing. She said she assumed the date on the statement was the date it was made.
74. Mr Jenkins took Ms Rule to a number of medical records. It is not necessary to set out all of them, given the agreement recorded in the schedule "R1" about what appears in her handwriting, but in summary most of these cards were ones on which she identified her own writing to record the weight (including those at page B642 and page B 851 for 14 July 2005, which had not previously been identified as her handwriting). She could not be certain who had written some of the figures for weight she was asked to look at. ON other occasions she expressed certainty about which figures were hers and which were Dr Berry's figures on the same page, although in fact they looked very similar. She agreed that in a number of instances where she had written the weight, the blood pressure reading was recorded in Dr Berry's writing, in the space which she had left on the card when the patient was checked in for the clinic.
75. In answer to the Panel Donna Rule said that the practice had been computerised for about one year at this time, and most aspects of the work were entered into the computer, except for the slimming clinic. She knew most of the NHS patients but they were treated the same as the private ones. If they saw Dr Berry they would come out of his room in possession of medication. The labels had the name of the medication on, but not the patient name or date of birth or instructions on how to take the pills.

76. Donna Rule told us that she did not run the clinic as Dr Berry did when he was present: she simply dispensed the pills and did their weights. When on her own she took the medication from his drawer and afterwards put it back, sometimes but not always locking it. She was not asked to take stock of the medication compared with the original number of tablets. If a patient who normally got 2 weeks medication asked for drugs and knew Dr Berry was going to be present the next week, she never reduced the supply to 7 days, but just repeated it the same as the last time Dr Berry had supplied the drugs. She had not been told to ask if the patients had any problems but if in the course of conversation it had emerged that they had a problem she thought she would have told them to see the doctor. She continued working in the practice because she liked the girls there.
77. We heard from Mr Barry Shiakallis in relation to different allegations which form the subject matter of charge xlii (an incident of breach of patient confidentiality). He adopted as true the content of his statement at A 339 – 345 in colourful terms: "it is 100% true. As we speak my wife is undergoing dental surgery and I am so convinced it is morally right I should be here to day, I am so convinced". He and his wife had been registered as patients at the practice from 1994 to 2003. They got to know Dr Berry, whom Mr Shiakallis judged to be lonely after a separation from his wife. Eventually, Dr Berry would pop in to their house (nearby his own), usually unannounced. On one such occasion, he had passed a house occupied by another couple (D and I) who were his patients, and said to Mr and Mrs Shiakallis that it was a pity that D and I could not have children. He said they had had tests to find out why. They were his patients. Mr Shiakallis thought he might have said that they were hoping to have IVF treatment. D and I were known to Mr and Mrs Shiakallis and they had had no idea of the problem in conceiving. Dr Berry's disclosure caused them to discuss between themselves what he might have revealed about them to others. On another occasion he revealed that another local couple, whom they knew to say "hello" to, had difficulty in conceiving and kept a chart showing the best time of the month to conceive. Dr Berry said when it was shown to him he had ripped it up and told the woman to go home, relax and then she would be able to conceive. He said she then became pregnant and took him a box of chocolates to thank him for his help. His statement also outlined some other occasions when confidential patient information had apparently, and inappropriately, been disclosed in a social context. They decided to limit their contact with Dr Berry.
78. Mr Shiakallis said he and his wife had formed the impression that Dr Berry became very possessive of their friendship. Dr Berry had told Mr Shiakallis about a nice hotel on the Isle of Wight where he had previously stayed, and on the strength of the recommendation the latter booked a family holiday there for himself, his wife, their two small children and his wife's parents. Some time before this holiday he picked up Dr Berry from Heathrow Airport on his return from a trip to India, and told him as he drove home that he had booked to stay in that hotel. Three days before the family was due to go on the holiday Dr Berry came round and said he was also going to be staying the same hotel at the same time. This caused Mrs Shiakallis to be upset, particularly when she found out that Dr Berry's ex-wife was going to be staying there at the same time. The Shiakallis family did not want the stress they anticipated from these arrangements. They were not pleased that (as they saw it) Dr Berry had chosen to accompany them on their holiday without consulting them. Mr Shiakallis produced the confirmation of his hotel booking for the period 14 – 18 April 2003 [C 1414].
79. Mr Shiakallis was challenged about both the disclosure of confidential information and the holiday arrangements. As to the former, it was put to him that Dr Berry was merely speaking about the fact that couples could have difficulties in conceiving, which could in some cases be resolved if they were less anxious, but that Dr Berry had not named anyone: rather, Mr Shiakallis had put two and two together to surmise who he might be talking about. Mr Shiakallis was adamant that he identified two couples, naming one and describing the other as "the family at number 13".
80. Mr Shiakallis was also questioned about an exchange set out in his statement to the effect that Dr Berry had suspected meningitis in a boy patient and referred him to hospital for appropriate treatment. He thought he was telling this story in a boastful way. When asked about this by Mr Jenkins he said he did not think it was right for Dr Berry to tell him that he

had done a good deed. He did not allege that Dr Berry had identified the patient, other than that he was from Waltham Forest.

81. Mr Shiakallis was a witness who saw things in very black and white terms. He was (or had become) hypersensitive about the confidentiality issue to the extent that he was critical about the disclosure of the fact that Dr Berry had correctly diagnosed meningitis in an unidentified patient. But he was very clear about the key facts that patients had been identified by name or house when confidential (and potentially embarrassing) medical information was casually disclosed.
82. We next heard from Mrs CC [statement at A 504] who was one of the patients about whom it was alleged improper disclosure of confidential clinical information had been made. She confirmed that she had been a patient for 11 years, and that Dr Berry had been supportive towards her. She confirmed she was the lady who had produced the chart which he had ripped up, before advising her to go home and relax and all would be well.
83. We heard from Hilary Todd, who had been a receptionist at the practice since 1999 and became senior receptionist after Jan Hutton left in October 2003. She recognised and asserted the truth of her statement at A 161 -164. Among other things that statement says that Mr Shiakallis complained to her "about three years ago" about Dr Berry's breach of confidence described above, and that patient DL had complained that she had been pestered by Dr Berry at her place of work and had in consequence left the practice, later returning on the basis that she only saw Dr Berry's partner. She also says that both Donna Rule and Jan Hutton have said to her from time to time that Dr Berry would not be at the slimming clinic on a particular evening and they would be doing the slimming clinic by themselves. She has also heard both of them say to a patient who telephoned: "It is only me who is going to be at the slimming clinic tonight, do you want to see me?".
84. Mrs Todd was clear in her oral evidence that when she started there were 3 boxes of patient record cards for the slimming clinic, which were kept initially in a cloakroom cupboard and then moved to on top of a glass fronted bookcase in Dr Berry's room. Then there were less than 3 boxes. She was not involved in the running of the slimming clinic, but encountered the patients. Some also came in during the day and were seen after the morning NHS list or if they came in the afternoon, before the NHS patients. She would see the slimming tablets in Dr Berry's room on a Monday afternoon. If patients came in during the day Jan (Hutton) or Donna (Rule) handed out the tablets.
85. Questioned on behalf of Dr Berry, Mrs Todd said she did not know if the handing over of tablets by Donna or Jan was pre-arranged. She worked until 6.30 on a Tuesday. She was asked to look at paragraph 30 of her statement and said that the only time Donna did the slimming clinic on a Tuesday was once when Mrs Todd was away on holiday and she had to cover. She was asked about his working practices. She said he like to do everything how he wanted it and badgered people to do things. She did not agree he was particularly motivated to run an efficient practice; he just wanted things done his way.
86. Questioned by the Panel Mrs Todd said that she had overheard Dr Berry making telephone arrangements about one patient when another was present in his room. She was not happy that patient details were kept confidential. She was sure that during all the relevant period up to the time the slimming clinic stopped operating, there was more than one box of record cards.
87. We next heard from Christine Ford (practice secretary until her retirement in May 2007) who recognised and declared to be truthful her statement at A 180, summarised at paragraphs 11-12 above. She further told us that she was required to write everything on a death certificate except the signature, which Dr Berry wrote. However she not only wrote but also signed prescriptions. She imitated his signature and did not sign them "pp" Dr Berry. He did a loop with his left hand but her loop went the other way. She identified11 signatures which were executed by her and 24 others which were not hers, among many prescriptions. She said that typically there were 20-25 prescriptions in the pile to sign. She did not see Dr Berry checking them afterwards. She was not happy about it and said to Dr Berry that the chemist would notice the difference, but Dr Berry said they were too stupid to notice.
88. She had no involvement with the running if the slimming clinic but on 23 May 2006 Dr Berry came in at 12.30, shortly before she was due to finish and asked if she could stay late to type

some lists. She said she sat at the computer and Dr Berry sat behind her to her left and had two boxes of record cards from which he dictated, turning over on the desk next to her. He was talking to himself and saying things like "there was nothing on that one". The job was finished at 2.50 pm. Dr Berry then picked up the cards and boxes and left the surgery carrying them. She never saw the boxes again. On the following day she was asked to type a further short list. She produced the lists at pages A 346- 353.

89. She agreed with Mr Jenkins that (as she said in her statement) Dr Berry said if there was a prescription for a controlled drug he would sign it. She also agreed he always said he had checked the prescriptions. There was usually just one pile of prescriptions; it was not a question of him getting tired and asking her to sign the rest. She could not know whether these were for patients in a nursing home. Asked further about the list typing on 23 May she said Dr Berry sat at the desk to her left and slightly behind her but she could see his hand turning over the cards on the desk.
90. Questioned by the Panel Mrs Ford confirmed that the prescriptions were generated by computer but when she was asked to sign they were already in Dr Berry's room. She did not know what Dr Berry was dictating from for the short list [A 353] prepared on 24 May 2006.
91. We heard from Ms Karen Leese who is responsible for the patient advisory and liaison service at the PCT. She had prepared a file note [A 508] following a telephone call from Ms DL on 27 October 2005. It reflected DL's complaint of being pestered by Dr Berry at her place of work. The note referred to fears she had expressed as to what the doctor might do after she had turned him down. It continued by referring to a second visit made by Dr Berry to her workplace, when he handed her a letter in front of her manager. She was desperate to stop him contacting her and was changing her GP practice. The note said "D has telephoned me on a number of occasions discussing the matter; she is very upset and feels he is harassing her." Ms Leese told us that the latter part of the file note relating to a second visit to the workplace was created on a later occasion (although the document does not identify it as a later addition). At A 509 is a handwritten letter which Ms Lees told us DL had posted to her on 14 November 2005. It enclosed the two further letters at A 510 and 511. A 509 says: "This [A 510] is a rough copy of the letter that I posted through Dr Berry's door of his home. Last week he again came to my place of work to hand me this letter [A 511] that I am sending you a copy of. It was in front of my manager and I felt so embarrassed. I am not meant to have anything personal with me while at my place in work. I just don't want him to approach me any more. Thank you for all of your help Karen [signed]". A 510 says: "Dr Berry, Just to tell you that I will not be able to go no a date with you. I am in a happy relationship with my partner. At the end of the day you are my doctor and I am your patient. I would appreciate no further contact of a personal nature." A 511 is a copy of the typed letter from Dr Berry to DL which he handed over to her at her place of work. Among other things it says "I am really sorry there was a misunderstanding between us. I have absolutely no desire to cause any kind of discomfort to you whatsoever….I did feel like a bit of afoul after than [being a local GP + asking a patient (the first time ever) but in no way so I think you were at fault…. I sincerely hope this has not compromised our doctor-patient relationship in any way. I will have NO problem in behaving as if this never happened, and very much hope you could do the same".
92. This was followed by an undated letter from DL to "the Health People" date stamped as received on 17 July 2006:

    "Dear Sir/madame,

    I wish to take things no further. I have said all I have to say to you. At the end of the day me and my family thought Dr Berry a very kind and caring doctor. Without his help in referring me to a very good hospital I might never of had my little boy after 3 miscarriages…" She referred to two other episodes where she appreciated Dr Berry's professional care. She added "Even after the unfortunate events of what happened with him asking me out, we still think a lot of him and miss him at the surgery. I just hope all this can be put down as just an unfortunate thing, as everybody makes mistakes in life. Sorry for the inconvenience but I don't have your number."
93. In cross-examination she was then taken to a copy of a letter produced by Dr Berry [D 10] which is a handwritten letter from DL dated 25 July 2007. It says:

    "Dear Karen Leese,

I wish to state that my contact with the pct has been misunderstood a Dr Berry has never harassed me at any stage. Further to them telling me Dr Berry had been discussing my husband's death and appalling treatment he received at Harlow Hospital, with other people, then that would have been with my full approval as I wanted as many people to know about Ian's awful suffering as possible …. It may have stopped others in that hospital suffering like Ian did. Dr Berry has always been a very very good doctor to me and my family and is greatly missed, he has only even been kind and caring and I do not think we will find another doctor as good as him. I do not want the pct to contact me any more."

94. In re-examination Ms Leese produced her original file, to show that the version of D10 (which she had received on 7 August 2007) was itself a photocopy. Moreover the edge of the page was slightly cut off on the right hand side, cropping some words, but was complete in the copy produced by Dr Berry as D10. It followed that Dr Berry had a more complete copy of the page than had been sent to the PCT. She was asked whether she had ever before received a letter starting with the words "I wish to state that…" and she said she had not. She said she had had no contact with DL after her letter of July 2006 until she received this letter in August 2007 and it came out of the blue.
95. Shelagh Byrne, a practice nurse, gave evidence to us in accordance with her statement at A 156- 160. She worked at the surgery on Tuesdays from 4 pm to 6.30 pm. On Easter Tuesday 18 April 2006 she came out of her room and saw a lot of patients waiting and was told they were for a slimming clinic. She had heard of it. She knew Dr Berry was on the premises at that stage and did not worry about it. She worked again at the surgery on Tuesday 2 May 2006. A patient was due to see her after seeing Dr Berry and she came out of her room at about 6.15 or 6.20 pm to see what had happened to the patient. She was told (she thought by Hilary Todd) that the patient had probably been seen by Dr Berry before he left. Hilary explained that Dr Berry had gone to play tennis. There were about four or five patients waiting for the slimming clinic. Then Donna Rule came in to the surgery. Nurse Byrne said Dr Berry was not there. Her statement says that she also said there was therefore no point in Donna staying, but Donna said she often did the slimming clinic on her own. Donna said, "Come in to Dr Berry's room and I'll show you." She took Nurse Byrne in to his room and showed her two tubs of tablets on his table, and Nurse Byrne said "How do you know what strength of tablets to give the patients?" Donna replied that it was all written on the cards. Nurse Byrne did not see the cards.
96. Nurse Byrne said her heart was pumping and she could not believe what she had seen, and had seen nothing like it in 33 years in the NHS. She felt she had to get out of the building. She phoned a good colleague for advice and subsequently reported it to the PCT a couple of days later. She had looked at her BNF for information on the drugs being used in the slimming clinic because she had not heard of them before. She had no subsequent contact with Dr Berry.
97. In cross examination she said she left the surgery at the same time as Dr Kansammy, who had nothing to do with the slimming clinic. She honestly did not know if Dr Berry had seen some slimming patients before he left that day. She had not seen Dr Berry deal with a single person. It was not suggested to her that she was in error about what she had seen or been told.
98. Another nurse practitioner, Ros Lock, gave evidence in accordance with her statement at A 165 – 168. When she started working at the practice she agreed with the two GPs that one of them would always be present at the premises when she was seeing patients. She said Dr Berry was due to be present every other Wednesday when she had her clinics from 4 – 6 pm but that became erratic after about 6 months. During the year prior to her statement (16 August 2006) she had hardly ever seen him on Wednesday afternoons, and this meant that if she needed to seek a doctor's advice about a patient, none was present.
99. In cross examination she said she did not know Dr Berry saw his children from school on Wednesdays. Nobody had told her he would be available to come in and see patients if called.
100. The PCT called four former patients of the slimming clinic: MG, RW, VC, and LK. None said that they had been seen by Donna Rule on her own during the evening sessions of the

clinic. MG said it was always Dr Berry who saw her and gave her the slimming tablets. RW had collected her tablets twice during the lunch hour from the reception desk.

101. MG [patient P 106: statement at C1464-5] was registered at another GP practice as a NHS patient. She first came to the slimming clinic on 16 January 2006 because she had heard you could get tablets there to help you [slim]. She was seen by Dr Berry and was given 2 weeks' supply of phentermine [Ionamin] on that first occasion. She could not be certain if he had asked for her consent to notify her GP. If he had done she would probably have said "yes". In fact her GP was not notified [nor were any of the GPs whose patients attended this clinic]. She said that on the first occasion he had given her a sheet with diet advice. Her statement indicated she received no other advice but in evidence to us she remembered he had said about doing lots of walking. On 30 January 2006 her record card [B821-822] had a record of her weight but not of her blood pressure [but this is an entry which is agreed to b be written by Dr Berry], and there was a further 2 weeks' supply of phentermine. However she said in evidence that she did remember that Dr Berry had weighed her on that occasion. On 13 February she returned and "had no had a huge weight loss" and Dr Berry suggested another pill which she tried for a time, but "it did not suit me so I reverted to the originals." She told us she was on blood pressure tablets at this time, and her blood pressure recorded by Dr Berry on 13 February was 160/80. On 27 March [page 822] she attended the slimming clinic and was given 4 weeks' supply of phentermine. Her last attendance was 24 April 2006 [the closure of the clinic following the PCT visit was 22 May 2006] when she received a further 4 weeks' supply. The entry for that date includes a marginal note in Dr Berry's handwriting: "leaflet s/e" [which Dr Berry later explained meant a leaflet concerning side-effects was given to her]. She could not remember if one was given and could not remember any discussion about side effects on that last visit.

102. MG agreed with Mr Jenkins that under the heading of previous medical history on her card were the letters "BP" but she could not say whether she had told Dr Berry of her actual history of blood pressure. If she had been asked her height she would have said 5 feet and a half. Mr Jenkins drew her attention to a handwritten figure of 5' above her weight on the record of her initial visit. She had lost 2 stones and was very happy.

103. In re-examination she said her husband had not been pleased when he found out that phentermine was an amphetamine, although she had had a fairly good idea from the start, because of talking to other people who had recommended the slimming clinic. Dr Berry had not told her that the tablets he was giving her could have an adverse effect on her blood pressure. If she had been told that whilst on them her blood pressure had gone up from 120/80 to 160/90 she would have asked about it. Dr Berry had not offered her the opportunity to lose weight without using medication. Asked about other medical conditions from which she suffered, she said she was also on treatment for an under-active thyroid and Dr Berry did not explain that may cause weight gain.

104. Ms RW [patient M 4] recognised and adopted her statement [C 1462-3]. Her record card was at B 525 and shows she attended the slimming clinic once from 16 May 2005 to 20 February 2006. Dr Berry had advised her that her weight would be governed by the amount she ate and that the tablets would help to suppress her appetite, that exercise would make no difference and that she should drink a lot of water. There was no discussion about dieting. He did not measure her height or ask her what it was. He took her blood pressure. He gave her a card containing information, but not about the medication she received. She asked him if the medication contained "speed" because of the similarity of the names phentermine and amphetamine. She asked this because she was planning to take up a post as a probation officer and could be randomly drug tested. He said it did not but part of the constituent was derived from the same base. She got tablets on her first and all subsequent visits. She described side effects she had experienced: a very funny dry taste, feeling sick and dizzy, and falling asleep. These were not things she had been warned about. She was sure there was nothing about this on the leaflet she had received. She said she attended the clinic on 9 occasions and B was not there on two occasions, definitely once, but this was when she went in her lunch break. There were several occasions when her blood pressure was not recorded on the record card and on two occasions neither blood pressure nor weight recorded, but tablets were supplied. On 27 July 2005 it is recorded that 14 days supply of Ionamin

(phentermine) was supplied: it is agreed that this record is in Donna Rule's handwriting. There is no note of blood pressure or weight. On 3 January 2006 she got 4 weeks' supply of tablets because she was going on holiday to the Dominican Republic. After that she started her job as a probation officer so decided not to carry on taking the tablets. In her statement she also says that she was influenced by the side effects she was experiencing and the appearance of the other patients attending the slimming clinic. She also said that patients she saw booking in to the slimming clinic did not in some cases look overweight and some were fairly young. Ms RW was sure that Dr Berry had not asked her if he could notify her own GP. It would not have been a problem for her if he had asked. She did not recall being asked to provide details of her GP. Her attention was drawn to the top of the record card where someone had written "Dr Cedar Clinic" which were words which meant nothing to her, as her doctor was Dr Macrae at Key Health medical centre, in Waltham Abbey.

105. She explained in cross examination that on the occasion she had picked up tablets during her lunch hour, she had spoken to Dr Berry in advance. She said she had not mentioned to him that she felt sick, which she put down to not eating very much, but in the back of her mind she knew she should not really be on the tablets. She had encountered four people at the clinic experiencing the same things. It was put to her that the previous name of Key Health clinic was Cedar clinic but she said she did not know that to be the case.

106. Asked by the Panel to clarify what she had meant by the appearance of the other patients, she said they appeared to be quite young and slim. She did not know if they had lost weight because of the tablets, but it seemed odd and she thought they were there for cosmetic not health reasons.

107. Mrs VC [patient P 62 where she is referred to by her unmarried name of VT] gave evidence. She too recognised and adopted her statement at C 1457-58. Her record cards were at B 727 – 728. She had attended the slimming clinic first on 7 April 2003, when her weight was 13 stone 7 lbs (she said she had just had her second child and was very overweight and unhappy), and continued until 16 February 2004 when her weight was 9 stone 7 lbs. She was not asked or advised about losing weight before being offered tablets. She was given a leaflet when she first attended and another one later on, and there had been some discussion of side effects of the tablets but she could not remember what. She was never asked to consent to her own GP being informed that she was attending the slimming clinic or taking medication, and this contrasted with the clinic she was currently attending, where she had signed a form giving permission for her GP to be informed. If Dr Berry had asked she would have consented. She corrected a grammatical nonsense at paragraph 13 of her statement to make clear that when she informed Dr Berry that she was having heart palpitations he advised her to step taking the medication.

108. In cross-examination she said that Dr Berry gave encouragement as well as tablets. At the beginning he had said her blood pressure was a bit high. He was always in attendance when she was there.

109. In answer to the Panel Mrs VC said her heart palpitations stopped when she stopped the medication. Her attention was drawn to the fact that her record card [C 728] shows a gap in her attendance starting on 16 June 2003 when her weight was 11 stone 2 lbs, until 8 September 2003 when she resumed, although her weight had meanwhile fallen to 10 stones. She said she had been going to a gym but had stopped when she was back at work and her weight had gone back up a bit.

110. Mrs LK [patient P158] gave evidence. She adopted her statement at C1455-6. Her record card is at C 937. The first entry noted is on 3 November 2003. She attended on a further 17 occasions until her final one on 24 April 2006, just before the clinic's closure. She was registered with a different NHS GP although had formerly been with Dr Berry's practice for a short time. Someone had told her about this slimming clinic. She said that she had been to a number of slimming clubs. She did not recall her height ever being measured or asked for. She did not remember being warned of side effects but had "been to a few of them", so could not remember which one told her it could keep her awake. We noted that this witness had obvious difficulty sitting still, or keeping her limbs still. She did not think she had been asked if Dr Berry could contact her own GP and if he done so she would have said "yes". Each time

she attended Dr Berry's clinic she had received tablets. She saw Dr Berry himself on each occasion.

111. She was asked when she last spoke to Dr Berry and replied that it was when he telephoned her at 8 am the day after she had spoken to "the man from the NHS" and given a statement. Dr Berry had asked what she had said and suggested she did not get involved. He had not said why. She had had to break off the conversation because she had to get to work. She did not know how he had got hold of her telephone number, which was not in the telephone directory, but thought it may have been from the mother of Mrs VC, who was herself a patient of Dr Berry. She was angry as to how people had got hold of the information. In cross-examination she agreed that her telephone number was on her record card and did not know the PCT had given Dr Berry copies of the cards. She also said to Mr Jenkins that she had attended on some occasions when Dr Berry was not there.

112. In answer to the Panel Mrs LK said she had previously attended a clinic run by Dr Berry's predecessor at the practice premises, about 3 years before she went to see Dr Berry [Mr Jenkins later established that that doctor had died in 1999]. She had last been to a slimming clinic about 6 weeks before giving evidence, and had attended slimming clinics for about 10 years. She last took some slimming tablets last week. She had not discussed with Dr Berry any concerns about being on the medication long-term. She was asked if she was concerned about the chance she had become addicted, and said she did not think she was as she often took tablets only every other day. She confirmed that her highest recorded weight was 10 stone 6 lbs and thought all her weights were within acceptable limits.

113. Mary Elizabeth Tomkins is the Assistant Manager or Medicines Management for North East Essex PCT. She was called to give evidence and adopted her witness statement at A 186 -188. She has the qualifications B Pharm, MSc, and FL Pharm S. She has 35 years experience of pharmacy. She was a board member of the PAG at the material time. She confirmed that phentermine and diethylpropion are controlled drugs under Schedule 3 of the Misuse of Drugs Act. A practitioner does not need to keep a record in the register but needs to prescribe them on his own responsibility. They are subject to safe custody requirements as defined in regulations. Essentially this involves locking them in a secure container which needs to be secured to the floor. A receptionist cannot legally supply these drugs; only a doctor or pharmacist or somebody working directly to their instructions, a limited supplier. Nurse practitioners have acquired additional qualifications but neither of these drugs would be able to be supplied by nurse practitioners. She referred to the history mentioned above of the withdrawal and restoration of a licence for the drugs, and said that although she had formerly believed they were not licensed, the product licences were reinstated. The licences issued in 2002 related to particular strengths of the tablets. Cambridge Healthcare Supplies Ltd, the suppliers of Phentermine, informed her that they only supplied that drug on a named patient basis to doctors and pharmacists. Records of supply are kept for more than 7 years. She explained that "named patient" meant a drug is supplied on the understanding that it is that patient only. Neither of these drugs was "blacklisted" by the NHS, and were therefore prescribable. Therefore they were available for a GP to prescribe to his NHS patients and should not be charged for privately to any patient registered with that doctor.

114. As to labelling, Ms Tomkins said that the minimum acceptable standard because pursuant to the Misuse of Drugs Regulations 2001 and Medicines (Labelling) Regulations 1976 was to show clearly the dosage and strength of the tablet as well as its name, instructions to the patient how to use it, the patient's name and the date of dispensing. The evidence as to the labelling adopted by Dr Berry is that the information was limited to the name of the tablets, the number of them and the strength.

115. When this case arose, she was concerned whether patients would need local support to continue treatment by another doctor, partly because of the potential for addiction and partly because the reason for the withdrawal of the licences originally was that there were concerns about the effect on the heart. The concerns about addiction were reflected by the advice that they were for short term use only.

116. She was asked about the cost of these drugs relative to two others more conventionally used in the NHS, Orlistat and Subatrimine. She could no remember the costs exactly and said the cost was not a big factor and safety always came first.

117. She agreed with Mr Jenkins that when she visited Dr Berry's practice many would have thought these two drugs were not prescribable but she had checked and they were.

118. In re-examination Ms Tomkins said the illegality came not with the licensing issue but with the supply to patients (both private and NHS). She said the information recorded in her note of a meeting with Dr Berry on 25 April 2006 that these drugs were not available on the NHS came from Dr Berry. Many professionals would have thought that. Others would know you could supply them but it would be regarded as poor practice.

119. Ms Tomkins told the Panel that there was no way a PCT could have been aware Dr Berry was supplying Schedule 3 drugs to patients privately. They would only obtain such knowledge via NHS prescriptions. Visits to GP practices were made at least once a year but this supplying would not be picked up unless it was a dispensing practice (which this was not). She said that issuing prescriptions to private patients was a grey area, but if it was available on the NHS a doctor could not prescribe them to his NHS patients privately. In further answer to the Panel Ms Tomkins said there was a requirement under Schedule 3 to all invoices of drug purchases but no requirement to keep a running total of those received and supplied in a register. The only records would be the invoices. Good practice nevertheless required a GP to write down what he has supplied from the total purchased. There should be a reconciliation between the purchase of drugs and the supply held, and the numbers of patients to whom drugs had been supplied, but Schedule 3 does not have that as a requirement.

120. In further re-examination Ms Tomkins said the only way these drugs could be supplied lawfully was on a named patient basis. She referred further to page 232 of Professor Wilding's report.

121. Expert evidence was called from Professor Wilding, who produced his report dated 21 August 2006 [A 225 – 239] and told us he stood by the opinions he expressed there, save for one matter he would deal with. His extensive experience in obesity management and research is set out at A 227. He is a member of the group currently developing NICE guidance on obesity treatment. Obesity (defined as a body mass index, or BMI > $30kg/m^2$) can be a chronic, distressing and disabling condition. Its management was generally considered to require an initial approach based on diet and an increase in physical activity, supported by written materials, clear advice and guidance. Normalisation of body weight was now considered an unrealistic goal and therefore most guidance suggested a target of 5 – 10% weight loss as reasonable. The Royal College of Physicians Guidelines (2003) set out essential requirements. Nine factors were listed. It is necessary to mention only suitably trained staff, specified weight loss goals, documentation of individual patients' health risk (EG blood pressure, glucose, smoking, other co-morbid conditions), an anti-obesity drug should never be prescribed for a patient whose BMI is less than that specified in the product licence, and an awareness that other therapy may need to be monitored and adjusted.

122. In Professor Wilding's view, treatment with drugs could be considered in patients who were well motivated but had not been able to achieve a target weight loss of 10% despite supervised efforts to modify lifestyle through diet, exercise and behavioural change over a period of 3 months. It was important to consider whether other medical conditions might be related to the obesity, or might alter the risk-benefit equation. Under some circumstances it may be appropriate to prescribe drugs to overweight patients with co-morbidity if the BMI exceeded 28, but only if that was allowed within the produce licence. Drug therapy should not be offered to patients seeking a quick fix for their obesity, without first giving them an opportunity to try and lose weight through a programme of diet and exercise first. Drugs should no be given to patients who were not obese or those with known contraindications to the drug.

123. Professor Wilding set out at pages 230-231 a number of factors for continuing management of patients being treated with anti-obesity drugs. Among these was notification to the patient's own general practitioner giving the reasons for the treatment, the dose and its intended duration and alerting the doctor to possible untoward effects.

124. Professor Wilding described the drugs which were currently licensed (Orlistat, Sibutramine and Rimonabant) and the management regimes which each required. The first two have been approved by NICE and the third is under appraisal. He also described "drugs

not currently recommended in the UK" which included phentermine and diethylpropion. The former acts on the central nervous system. It is thought to suppress appetite and possible have a modest thermogenic effect. He said it has been evaluated in trial of up to 36 weeks and there are few data on its effects on obesity co morbidities. It remains available in the USA and Europe. In the UK its licence was withdrawn (as described above) and finally reinstated on 24 December 2002. It remains a controlled drug and its use is no recommended either in the British National Formulary (BNF) or in obesity guidelines such as those issued by the Royal College of Physicians, because of concerns about dependence, central nervous system side-effects and the lack of long-term safety and efficacy data compared to other products. Diethylpropion is a centrally acting anorectic agent, and is a derivative of amphetamine. Professor Wilding's report said there was little data available on its efficacy, which had only been tested in short-term trials. However it was more effective than a placebo at producing weight loss, but there were concerns because of its stimulatory effect on the central nervous system and potential for dependence. It had side-effects including on the cardiovascular system (rise in pulse rate and blood pressure, and may lead to palpitations) and central nervous system (stimulation, anxiety, nervousness, dizziness, insomnia. Euphoria, depression, and headaches were occasionally reported). Lastly psychological and physical dependence may occur. Diethylpropion was contraindicated where there was cardiac disease or moderate to severe hypertension. Or where there was concomitant use of antidepressants, or with primary pulmonary hypertension. Similar concerns lay behind the fact that diethylpropion is not recommended.

125. At A 233 Professor Wilding set out the responsibilities of a prescriber of controlled drugs, including avoidance of creating dependence, and keeping a close eye on prescribed amounts to prevent patients accumulating stocks. Drugs such as diethylpropion are required to be stored in a locked receptacle such as a controlled drugs cabinet or approved safe which can only be opened by the person in lawful possession of the controlled drugs or a person authorised by them. Regulations also prescribed that the locked cabinet should be made of metal with protected hinges, fixed to a wall or floor with rag bolts. Phentermine is not subject to safe custody requirements.

126. Professor Wilding identified a number of criticisms of Dr Berry's management of his slimming clinic and patients, based on the criteria he had outlined. They are more fully set out at A 234- 237, but for present purposes may be summarised:

    i. General approach: little evidence of time spent discussing lifestyle approaches and using pharmacotherapy as the main treatment option. Charging his own NHS patients and NHS patients from other practices for the drugs he supplied when many would have been eligible for NICE-approved drugs management from their own GP.

  b. Likelihood that drugs were stored insecurely, and allowing a receptionist to dispense the drugs, not good practice and not consistent with legal requirements.
  c. Inappropriate delegation of dispensing controlled drugs to medically unqualified staff on occasions.
  d. Various instances of inadequate history taking and inadequate examination of patients.

    i. He was particularly critical that the only physical examination ever recorded related to body weight and blood pressure; height was only recorded in a few patients. This is necessary in order to calculate the BMI. At present drugs can only be considered if the BMI is > 30 or > 28 if obesity related risk factors such as diabetes or abnormal lipids are present. Some of the patients weight as little as 9 stone, at which weight a person would have to be only 4 feet 6 inches in height to be classified as obese. He referred to the patient whose record appears at page 621 to illustrate the mischief of not recording BMI when the starting weight was 9 stone 8 lbs and the patient's weight fell to 8 stone 11 lbs over the next 10 weeks or so.
    ii. He also criticised blood pressure recordings to the nearest 10 mm Hg only.
    iii. No other physical examination was recorded. In a case such as VK (patient 181) where there is a note that she had had an operation for a hole in the

heart, he considered a cardiovascular examination was important before prescribing medication which might affect the heart. There was no evidence he had elicited other complications of obesity, for example diabetes, or sleep apnoea, and none were tested for diabetes or dyslipidaemia.

iv. Inadequacy of advice regarding non-pharmacological methods of weight management.

v. Prescription of diethylpropion and phentermine and the adequacy of monitoring arrangements and duration of treatment. Professor Wilding criticised the supply of drugs at most visits irrespective of whether the patient had lost weight or without regard to blood pressure. He identified patient AA [4] who received phentermine on 3 occasions when her blood pressure was 160/100, 160/100 and 155/100.
Patient SJB [11] had phentermine on several occasions in 2002 despite gaining weight.
Patient CB [24] had phentermine on several occasions in 2004 when there were long gaps between prescriptions of 2 weeks' supply, so the patient never had a chance to see it the treatment would be likely to help.
SB [27] had no weight loss and was only 9 stone 12 lbs.
Some patients were prescribed drugs for longer than the recommended 3 months: for example patient AH [6] had phentermine continuously for 10 months.
Some patients did have their height recorded (eg patient HJ, number 153) and had a calculable BMI which was therefore not obese or even overweight and should never have been prescribed phentermine. Similar criticisms were made in relation to patient LJ [170] CL [192 – record card at B 953] LL [195 – record card at B 959].

vi. Professor Wilding was critical of the advice given on potential side effects, save that there were a number of notes of such advice after 24 April 2006, which was the date of the first visit by PCT officers.

vii. Lastly he was critical of the apparent failure to inform of these patients' GPs of the slimming treatment being given, or discussing doing so with the patients.

127. Professor Wilding's summary conclusions are set out earlier in this decision.

128. He was taken through these elements of his opinion in evidence. He said he has not seen phentermine or diethylpropion within the NHS for the last 6 or 7 years. He said the clinical trial data was very limited and the largest were only for 100 – 200 patients, so we do not have adequate safety or efficacy information on them. Questioned further on BMI he said we are all advised to keep our BMI in the range 18 – 25. 25 – 30 may be considered overweight. Over 30 is obese. BI is weight divided by height in metres squared. He said guidance on recording blood pressure was to do so to the nearest 2. Records are sometimes written to the nearest 5. These were rounded to the nearest 10. He had only been able to find one example where a drug had not been prescribed on the first visit by a new patient. Among other examples of the criticisms set out at paragraph 126 above, he pointed to patient P 4 at page B 605 where phentermine was given despite consistently raised blood pressure. This patient was not previously hypertensive, but had become so on this drug.

129. He said he had taken into account that fuller notes are kept in a hospital setting and that GPs historically make fewer notes. There was a minimum requirement for example recording height so that you can work out BMI. Challenged about whether the absence of a written record of advice given may not mean no such advice was given he agreed this was theoretically possible but thought it striking that in that event such advice was recorded in May 2006 (following the visit by PCT officers) but not previously. He said that if DR Berry had seen patients and not given them treatment, but noted nothing down about that, that was a failure too, as it was important to note a consultation. He agreed that treatment depended on patient co-operation and attendance was difficult to regulate. He had not criticised the fact that it was run as a drop-in clinic.

130. Professor Wilding was challenged about the track record of Orlistat and Sibutramine. He said he preferred these drugs which were approved for the purpose on the basis of adequate research data, but drugs should be reserved for people with significant obesity. There were some side-effects (few drugs had none) and you have to balance the risks. The reporting of deaths was very dependent on the number of prescriptions issued; we do not know the differences between how these drugs are used. The NHS approved drugs have significant clinical trials of (in the case of Orlistat) 4000 patients and another on cardiovascular outcomes for Sibutramine of 10,000 patients. There were few if any deaths and the trials were still running. With phentermine the trials involved only a few hundred patients and there was no real data.

131. He agreed that doctors had to use their judgement in choosing drugs and said they should keep up to date for that reason. He was concerned there were risks associated with long term use. There were patients of Dr Berry who had had the drugs intermittently for periods of a year or more, when the guidance said it should be used for no more than 3 months.

132. He agreed he had seen nothing to show patients actually came to harm, nor were there complaints from patients. The absence of complaints from other doctors may be because they were not informed their patients were attending this clinic. He agreed with Mr Jenkins that there was one case where a high blood pressure was referred to a GP before May 2006.

133. Questioned by the Panel Professor Wilding said the vast majority of obese patients were dealt with in the GP setting and not referred to hospital unless over 40 BMI or with co-morbidities. Potential complications of obesity included Type 2 diabetes, which was strongly related to body weight, hypertension and dyslipidaemia. Others were cardiovascular complications. Some papers did suggest that waist circumference was a better predictor of health than BMI, but the guidelines are related to BMI. Lifestyle adjustments helped about 20% of people to lose 5% weight in 3 months. Drug therapy added to weight loss by about 3 or 4 kg on average and increased the proportion of patients who hit their target weight loss. He agreed that the guidelines to which he had referred were simply guidance as to good practice and practitioners were at liberty to use their individual judgement. He judged that at least one third of patients given drugs by Dr Berry were not overweight or obese.

134. As to reasons for being overweight or obese, he said that he would (and a doctor following good practice should) investigate and consider what other medical explanations there were or may be for that, and if he found reason to suspect some co-morbidity, he would follow that up.

<u>Evidence for Dr Berry</u>

135. By agreement, various witnesses were interposed and in the event, Dr Berry gave his evidence after that of his expert Dr Martin Shutkever.

136. Dr Shutkever's report dated 24 October 2007 is at D 387 – 414. IN effect he was reviewing Professor Wilding's report against the documentary evidence and commenting. He candidly summarised his conclusion:

> "In my professional opinion, there are some patients where I agree with Professor Wilding that the prescribing of weight loss medication by Dr Berry was inappropriate. However on other occasions where the Professor has criticised the prescribing I disagree. At this stage I have not been able to look at the records of every patient to establish if the cases criticised by Professor Wilding are representative of most cases or are just a small number chosen from a much larger group. However I note Dr Berry's submissions analysing the totality of attendees. These suggest that some of Professor Wilding's criticisms should not be directed at the generality of Dr Berry's treatment and only apply in a small number of cases."

137. Dr Shutkever is a full time NHS GP and has not been involved in the treatment of obesity of overweight patients in the private sector. However he is aware of patients of his who have made use of such services and discussed issues with colleagues who have worked in diet clinics.

138. Dr Shutkever did not take issue with any of Professor Wilding's background explanations or discussion of the legal status of the drugs and their management. He also agreed that in general drug therapy should only be used in conjunction with advice on diet and exercise. He

acknowledged that Dr Berry had recorded "relatively few details about lifestyle discussion" but observed that GPs make briefer notes than hospital doctors and the notes may only capture specific details rather than general discussions. He rightly pointed out that the extent of such advice given was a factual question.

139. Dr Shutkever said that the NICE-approved drugs were relatively new and expensive compared to older drugs such as phentermine or diethylpropion so that on costs grounds a number of doctors in the private sector continue to prescribe the old drugs. They are widely used in other countries. He did not interpret the guidance of the Royal College as a prohibition on these two drugs. He addressed the issue of supplying them for a charge. He defended the choice of these drugs on costs grounds, as argued by Dr Berry himself, while acknowledging the issue as to whether it amounted to prescribing or dispensing. The legal status of the two drugs was complex, and many doctors and pharmacists thought at the time that neither phentermine nor diethylpropion were prescribable on the NHS and were surprised to discover that they were.

140. He felt unable to comment on the security of storage of the drugs and their issuing because there were factual disputes about what in fact happened; Dr Berry said he was always present when controlled drugs were issued to patients. He agreed with Professor Wilding's comments on the responsibilities of a doctor in respect of storing and issuing controlled drugs.

141. There were again factual issues relating to the delegation of functions of issuing drugs to unqualified staff. Dr Shutkever did however state (2.11) that some duties can be delegated (eg measuring weight or blood pressure) but not the issuing of controlled drugs.

142. Turning to section 4 of Professor Wilding's report as to individual patients, Dr Shutkever said in summary:

a. He disagreed that it was helpful or a relevant aspect of the history taking to explore why the patient may have gained weight (in brief because patients claim to be baffled). History taking in general was important. His reading of the records indicated Dr Berry had a consistent system, and recorded relevant information, which was adequate in the context of a community-based clinic.
b. He agreed that measuring height, weight, pulse and blood pressure were all necessary but it was not vital that all were recorded. He described the absence of any recording of BMI and few of height in the records he had seen as "not an ideal situation". If Dr Berry had asked the patients their height, as he contended, then he was not critical. But "not recording a BMI misses an opportunity to establish that treatment was indicated and it would be fairly standard practice to at least record the height so that BMIs could be established at any subsequent time if the weight was known".
c. Dr Shutkever addressed the criticism that drugs for obesity should be prescribed normally where the patient is obese (> 30 BMI). He observed that BMI was no the only way of assessing metabolic risk. Some authorities put more store on waistline measurement. He said that his own practice parameters were the same as those described by Professor Wilding, but he thought that in the private sector a patient may request treatment that would not be considered appropriate in the NHS.
d. There were minor disagreements of calculating BMI for some of the "non-overweight" patients identified by Professor Wilding, but there was no serious disagreement with him on this score.
e. Dr Shutkever agreed that in the majority of cases blood pressure was recorded to the nearest 10 and may have led to an underestimation of blood pressure in some cases. He would accept measurement to the nearest 5 mm HG as reasonable. However he did accept Dr Berry' contention that raised blood pressure is only diagnosed after a series of raised readings, not a single one.
f. As to the failure to perform cardiovascular examination on a patient who had previously had a hole in the heart operation, he said that he would not be critical if Dr Berry were sure this was no longer a problem.
g. He would qualify the criticism of no testing for diabetes or dyslipidaemia to patients who were middle aged or elderly.

h. He felt there was some evidence that Dr Berry used diet sheets and therefore did not agree with this criticism by Professor Wilding.
i. He considered the 10 patients in whom Professor Wilding identified concerns about the use of one or other of these drugs:
    i. He agreed that patient P4 should not have been prescribed phentermine;
    ii. He pointed out that patient P 193 (persistently raised blood pressure) had eventually been advised to consult her own GP and the medication stopped.
    iii. As to patient P11 (continued to get medication despite putting on weight) he was not critical overall of the manner of prescribing as there had been some initial success, although possibly some doctors would have stopped the medication sooner. He said there was little in Professor Wilding's criticism.
    iv. He thought there was little in the criticism relating to patient P 25 (long gaps in the prescriptions and the patient did no lose weight). This patient was in his view not really engaging with the treatment.
    v. As to patient P27 (started at 9 stone 12 lbs and did not lose any weight) Dr Shutkever said there had been 4 separate unsuccessful attempts at weight loss. While some doctors would have decided after the first two episodes that further attempts were not appropriate, there was room for different views.
    vi. A similar comment was made in relation to patient P5 (continuous prescribing from 25 October2004 to 8 August 2005) as there were detectable gaps.
    vii. Dr Shutkever agreed that in relation to patient P132 medication ought not to have been given to a patient with a BMI of 24.4 and similar considerations applied to patients P166 and P169. The same applied to patient P 233. If Dr Berry's evidence that he had obtained the waist measurement of the patients 169 and 233 then a case could be made that there was reason to consider both to be metabolically at risk. It follows that the first two mentioned patients should never have had drugs, and the last two cases depend on a finding of fact.
    viii. Dr Shutkever did not disagree that warnings were necessary as to side effects of the drugs but said this was a question of fact.
    ix. He agreed that Dr Berry had a duty to discuss with patients whether they agreed to his passing information to their own GPs but his experience was that they were often reluctant. Again this was a factual matter.

143. In oral evidence Dr Shutkever said that despite NICE there remained a body of doctors who continued to prescribe the older drugs. They could be used but he did not advocate their use. The cost of Orlistat was about £10.78 for a week and he usually found that the price to the patient was about twice as much as this NHS price. He reiterated that the format for history taking was adequate and covered the main areas. He admitted that it was not ideal not to record BMI, and you should know this at the outset because this is how you gauge success. He personally used a BMI of 3 as the threshold for treatment or 27 if there was co-morbidity: this was the same practice as described by Professor Wilding. However it could be said that over 25 BMI patients were at higher risk (cardiovascular considerations arose here). You would need to see the patient to get an overall view.

144. If a patient had a normal weight or BMI less than 25 it would be wrong to prescribe slimming drugs, unless there were metabolic risk factors.

145. Cross-examined for the PCT, Dr Shutkever said there was nothing in Professor Wilding's evidence with which he disagreed except his evidence of the proportion of patients who should not have been treated at all (one third). He thought the Professor placed more weight on the guidelines than he might.

146. Dr Shutkever said he had been appointed to a PCT in 2001 and agreed that if it had come to his attention that a private slimming clinic was operating when no doctor was present and when controlled drugs were handed out, he would say that was unacceptable practice.

147. He agreed that from his reading of the records it was the norm for drugs to be used as a first line of treatment for weight loss. He would not regard that as acceptable in NHS practice but it might be different in private practice bearing in mind that people have tried to lose weight. It was suggested to him that he could not seriously advocate that a patient attending for the first time should be given medication on that occasion, and he agreed that they should prove they are motivated first, however he was also a realist and some people would not follow advice to lose weight so he thought in the private sector it might be justified to have readier resort to medication. He did not have any experience of prescribing in the private sector personally. These drugs were legal and worked so there are some benefits. He later said that in a private setting it may be acceptable to prescribe drugs at a lower threshold than BMI 30 if we were balancing risks against benefits. This was a logical argument but he did not do it himself. His logical argument was based on it being a private clinic

148. His report not having commented on the fact that Dr Berry was charging his NHS patients for supplying these drugs, he was asked to do so, and Dr Shutkever said he should not have done so.

149. Dr Shutkever was also asked to say how frequently blood pressure should be measured. In his opinion it should be done on each occasion a patient was seen, save perhaps not as often as every 2 weeks. He was later shown the patient record at B 576, where he accepted that there were 14 attendances with a blood pressure recorded on 8 of those occasions over an 11 month period. He accepted there were 3 examples of a gap of a month or more.

150. He accepted that height should be measured and BMI calculated and recorded. If Dr Berry was not assessing the BMI "that would not be adequate". A sufficient history should be taken to rule out any contraindication for the drug. Patients should be warned about side effects.

151. A number of Dr Berry's former patients were called by him: Mrs DT, Ms JK, Ms JN, Ms VK, Mrs C, Mr C, Ms DP, Mrs KR, Ms LP and Ms KB. They were very supportive of his qualities as a doctor and on occasion openly critical about the conduct of the PCT in suspending and then removing him. Most had attended his slimming clinic from time, and these all made a point of saying that Dr Berry was always present and checked their blood pressure. Most added that he asked if they were experiencing any side effects.

152. Mrs DT was asked to consider the absence of a history on her own record card and said she would not have expected Dr Berry to take her history again because he was her own GP. She could not understand why there was no recording of her blood pressure from 4 May to 12 July 2004 and conceded he may not have taken it every time. She was the person named by Mrs LK as the probable source of information to Dr Berry that Mrs LK had given a statement to the PCT. She said she knew that lady had been seen by a Mr Greenwood from the PCT "but I did not tell Dr Berry myself". However when questioned by the Panel she said she had had contact with Dr Berry before the date on which he telephoned Mrs LK. She said she discussed with Dr Berry a supportive letter she had written.

153. Questioned further by Mr Booth she was shown a copy leaflet from the NHS surgery run by Dr Berry (A 148) which draws attention to the existence of a weight reduction clinic in the NHS service. She said she was never told about that by Dr Berry.

154. Mrs JK was a long-standing patient and the mother of another witness Ms VK. She had got up a petition on behalf of Dr Berry.

155. Ms JN [patient N 17] had been an NHS patient of Dr Berry for 10 years and found him considerate, and kind. He listened and explained things. She had attended the slimming clinic and lost 1 stone 10 lbs.

156. In cross-examination she said she had been refunded £100 by Dr Berry (she was an NHS patient) following his suspension. Her record card [B 575] disclosed a history of hypothyroidism and she was taking Thyroxine. She acknowledged that an underactive thyroid would cause her to "hold weight". She never felt that the tablets had been affecting her but she had a dry mouth. She could not remember why she had changed the medication on 4 July 2005. She had been to other slimming clinics before and after this one. She too said Dr Berry always took her blood pressure. She agreed that her weight was recorded on most but not all occasions. She said that "I have taken slimming tablets mot of my life. I last took them about 3 months ago".

157. Questioned by the Panel Ms JN said she had regular blood tests for her thyroid function, and agreed that her weight on 18 October 2004 was 10 stone 11 lbs and a year later (after 14 attendances) had gone up by 1 lb. She did not seem concerned by this, reasoning that "I would have been a lot bigger [but for the tablets]". She said she was 5 feet 5 ½ inches tall.

158. On the fourth day of the hearing Ms VK said she attended the slimming clinic and Dr Berry was there each time and took her blood pressure as well as weighing her. She never had any side effects "except I found it hard to sleep". She said he got the record cards out of a drawer or got it out of a glass cabinet. She volunteered that there was only one box that she saw. Other accounts we heard suggested that the receptionist took the card in to Dr Berry when the patient arrived.

159. This was the patient who had had serious surgery when she was aged 10, for a hole in the heart. She had taken Tenuate Dospan off and on since the age of 18. She agreed with Mr Booth that looking at her record card [B 572-2] during a period November 2003 – March 2005 there were three or four occasions when there was no recording of blood pressure but she still maintained it was done every time. She was an NHS patient of Dr Berry who, like the others, had paid £10 to register and £10 for each week's medication. She was asked if she had been repaid any of that and she said she had received 3 cheques, one for £10, another or £90 –something and just recently £100 +. She had bumped into Dr Berry in Tesco and told him one of these cheques had gone out of date, and he said he would replace it. She told us she had said to him "I will come as a witness any time you want".

160. In answer to the Panel this witness said she was not a frequent attender at her GP clinic for normal health problems. When she attended the slimming clinic for the first time she did not know if Dr Berry opened her NHS computer record, but she believed he would have known about her hole in the heart. It had not struck her as strange that he was using a different recording system for this clinic. She had not been offered referral to a dietician but said she had had advice to eat a regular breakfast and plenty of veg and to walk and go to the gym. Looking at her record card on page B 571 she agreed that her first recorded weight was 11 stone 3 lbs and her last recorded weight 11 stone 2 lbs but said her weight did fluctuate up and down. She said "if you are not going to work at it that is my fault". Dr Berry had no suggested to her that as she was not losing weight on a sustained basis it might not be appropriate to continue the medication. She would have remembered if Dr Berry had informed her that a slimming clinic service was available free and she had no such memory.

161. Mrs DC, Ms DP and Mrs KR spoke of Dr Berry's excellent care for them or near relatives. They had in fact written supportive letters but said Dr Berry had no told them what to put in them.

162. Mr C (husband of Mrs DC) gave evidence, like his wife, denying that they had ever complained of Dr Berry's treatment of his wife's mother.

163. Mrs LP, a patient, was interposed later. She referred to her letter at D 113 and her evidence on a previous occasions at D 361. She said Dr Berry had been a fantastic doctor to her. She was also a slimming patient of his. She had struggled throughout her life with weight and with his help kept it steady. She was always weighed and had her blood pressure taken. It was not her experience that Donna Rule did clinics on her own. Over 6 or 7 years she had been given pills by the receptionist sometimes when she had rung and told Dr Berry she could not make his clinic, and he left out a week's supply for collection.

164. In cross examination she said the registration fee [B 583] was refunded in 2006 and she had received 2 further cheques, the first of which was £100 and no long afterwards a further cheque. Looking at her record card she agreed there was no record of blood pressure on 2 April 2000 and again in May 2000, although she seemed to remember it happened every time. Her attention was drawn to a note in the left hand margin for the date 17/4/00 which said "leaflet" (one of several marginal entries on cards in the column usually reserved for the date). She said that would be when she was given a leaflet about side effects and a slimming sheet although she thought this had been on her first attendance (March 2000). She was unable to recall why (according to the record card) she had changed the drug on 4 April 2005, but thought it might have been because she was having difficulty sleeping. In re-examination she said that the cards came from a box and there was one box.

165. The last patient called on behalf of Dr Berry was Mrs KB who produced her letter of 3 January 2008 [D 442]. She was a slimming patient. She said when she first attended her blood pressure was taken and her weight recorded and Dr Berry went through the contra-indications for the drug. A receptionist knocked on the door and put a single box of records on the desk. She said she had to go and would "leave these here for you". This was in January 2006.

166. In cross-examination she said the letter came to be written when Dr Berry telephoned her. It was her first contact since the slimming clinic ended in May 2006. She presumed he got her number from the patient records. He asked me to talk through her experience of the clinic. When she first attended she was given a leaflet, a pot of pills and a little drug sheet, and a diet sheet. They discussed exercise. She also said she was asked if she wanted her GP to be informed but she did not. This was the only patient who gave evidence that such a request had been made to her.

167. In answer to the Panel she said the initial consultation took longer than the others because they talked about diet – about 12 minutes. Subsequent ones took about 8 minutes. She worked for Pfizer which provides services to primary care mostly towards cholesterol support. She did no know if Pfizer had any input to Dr Berry's practice. She did not think Dr Berry had made a special effort towards her because she worked for Pfizer. She was asked about the record cards. She said Dr Berry had hers on his desk already. The receptionist had a little drug box plus a list. She indicated a box about 6 inches square.

168. Mrs Chris Argyrou is a registered nurse and is the clinical director of Paternoster House, a nursing home for people with physical disabilities or dementia. The local GP practice where her patients were registered was Dr Berry's. She spoke well of his willingness to respond to calls, and doing rounds. He took time to speak to the patients and she did not regard him as being short with them.

169. IN cross examination she said the nursing home generated a large number of prescriptions, and she knew that Dr Berry did not sign them all, as he shared the care with his GP partner. She was not aware that any had been signed by a secretary.

170. In answer to the Panel Mrs Argyrou said her nursing home paid an annual fee to Dr Berry's practice to ensure they were covered, although this was an NHS service and the patients were his NHS patients, and he did not provide any services over and above the normal NHS needs.

171. Dr Berry's evidence was heard in three tranches over three days while other evidence was interposed fro the convenience of his witnesses.

172. He produced his CV [D 1-2]. He summarised how he came to restart a slimming clinic which had formerly been operated by his predecessor in the practice, Dr Sultana. He also referred to testimonials from Consultants at D 3-9 excepting page 8. He produced an appraisal summary [D 272] from 2005 in which he mentioned his private slimming clinic as he had done under a previous system every year, and therefore said that the PCT should have been aware of this. When he re-started the slimming clinic in 1996 he looked up to see what drugs people were using and what drugs Dr Sultana had been using. He had used these drugs before (but not in a slimming clinic) as they were very old.

173. It was an open door clinic, each Monday evening. Some of the patients were his own NHS patients. Generally, patients had tried all sorts of things before they came to him (such as weight watchers or their own GP). He thought phentermine and diethylpropion had been blacklisted for the NHS strictly on cost grounds by Ken Clarke. The NHS patients were treated the same as private patients. They could not otherwise get these drugs.

174. Dr Berry accepted it was incorrect to use FP4 record cards belonging to the NHS in his private clinic, but he was used to the format.

175. He described the system on first attendance: register at the desk, with information including their own GP, pay the receptionist the fee. The receptionist wrote the headings on the record card so that he had less to write. He said he always asked if they wanted him to notify their GP. In fact he had never recorded their response, but he "never had anyone agree to inform their GP". He then asked why they were here, and what did they want from the clinic. He then went through a history and elicited things like depression or thyroid problems.

If he thought there was a problem he would say they must get back and tell their own GP. They were generally young fit people.

176. Dr Berry said he then checked their blood pressure and felt the pulse. If there was an indication of a medical problem he would look further into that, but in 95% of cases there was not. He then weighed them and asked them what their height was. He would then glance at a BMI table he had on his desk to see where they fitted in. Some were grossly obese you could see that. He had recorded some heights when it was borderline for weight and then he wrote it down to remind him it was an issue. But not otherwise.

177. He had further discussion after he was satisfied the patient had tried different things, and gave them a diet sheet and talked about the need for exercise, and then about how the drugs actually worked (about which they often had not idea). He said he stressed the need for discipline to ensure there was long term weight loss.

178. Dr Berry said he told the patient that they could take one tablet a day with a glass of water, whole, and stressed that they should eat sensibly and told them the pills suppressed appetite.

179. Asked about side effects he said the main was the interaction with pregnancy. If they were thirsty or experienced effects on their sleep that was not a reason to stop, but if they had palpitations they should stop. He said there was a risk of addiction but he would be watching carefully for that. He said there was a rare risk of pulmonary hypertension.

180. As to information leaflets, he said that he sometimes gave out leaflets at the outset and sometimes not. He explained this puzzling practice by saying that he was keen to reinforce information on side effects and therefore might decide to give the leaflet to the patients on a later visit. In relation to patient VK he noted the word leaflet and a tick. This was a leaflet about side effects [D 168] and was marked by him to illustrate what he gave to patients. He listed the following that each patient would be given: diet sheet, leaflet on side effects (subject to possibly doing it at a later date).

181. He kept the tablets for patients in a bottom locked drawer. I would take out the bottle and he "used phentermine as the first line of treatment". The bottle had a label on with the amount and the name of the drug and what to take. He would give the patient a supply for 2 weeks and tell them how much weight he expected them to lose and also to tell him it there were any problems. He said he was "very anxious patients should be informed of the risk of side effects".

182. He said he got his supplies from Essential Nutrition of from Cambridge Healthcare, and referred to the letters from those two companies at D 162 and 163. In the latter case the writer confirmed "these were despatched under a named patient basis as per your script". He made up the bottles of pills at home and put them in a locked drawer of his desk.

183. As to the drug storage at home, he referred to a photograph at D 353 if a safe in his garage which he said was fixed to the wall, "but disguised to make it look as though it is resting on a box".

184. Record cards were kept either in a cabinet or on top of the cabinet in his consulting room, or sometimes in the drawer next to the box of pill bottles. The cards were kept in one drugs company box, and he stressed that he "only ever had one such box".

185. Dr Berry told us of the encouraging approach he adopted to patients on subsequent visits. He took blood pressure and weighed them. He acknowledged that "officially you must no use [these drugs] for longer than 3 months which I tried to stick to, but if they are still not doing well after 6 weeks I tried to get them off the tablets".

186. Only the receptionist and Dr Berry were present during the slimming clinic. First it was Jan Hutton and later Donna Rule. The receptionist wrote the headings on the cards for patients who were to be seen. They had no role in taking blood pressure or handing out medication. However "if I knew I could not be there I agreed to leave them with the receptionist and ask her to weigh [the patient] so as to have a record".

187. Dr Berry said he took very little holiday and if he did it was for 4 or 5 days to the Isle of Wight. In that case he told patients he would not be there so that they could take medication for one or three weeks. If a patient could not do that he allowed the receptionist to hand the medication over. If there was a Bank Holiday on the Monday the slimming clinic was held on a Tuesday. Most patients avoided that. Donna Rule never came on a Tuesday. If patients

were unable to come to the clinic, they would ring him up and he would discuss a different time or date if they were happy to leave the medication with the receptionist. If he knew the patient well he would check the cards and say OK, but not if they were a new patient he did not know well.

188. A patient might therefore have a discussion with him as a result of which she might get pills from the receptionist.

189. Dr Berry produced a letter from his accountant [D 350] giving an income from the clinic of £3400 in 2006 and £2400 in 2005. But he had returned £3-400 of patients' money in 2006-7. He had returned the registration fees to NHS patients and when he later got the record cards back he made a further payment to repay the money he had charged for supplying drugs.

190. Dr Berry described Donna Rule's allegation (that she had sometimes operated the clinic on her own) as ridiculous. He said "I don't know why she would say that". He said he was rarely away from the practice. If he had to be away he would carry a phone and the receptionist was told that if something unexpected happened if he had left early they should ring. He did no live far away. There were times in earlier years when it was quiet so there was no point in both of them hanging around. If he went early he could return by car in one and half minutes.

191. Dr Berry was taken to the letter at D 24 produced by him but written by Donna Rule (see her evidence at paragraph 62 above), in which she resiled from her earlier statements to the PCT. He said this letter was right, except that the last bit was probably not right as there were some occasions he had left tablets for to hand out. He said he had been her GP in the early stages of the pregnancy and felt good that she had had a successful birth, so popped in to take some flowers. He had not received the final PCT report at that stage but had received the interim report. He said "I had no idea that Donna had written statements to the PCT". When he came in Donna said to him "you'll be back, it is nothing, it is just what a nurse practitioner was saying". But Dr Berry said he told her "Shelagh Byrne is saying that you told her I had been getting you to hand drugs out." She said to him "I can sort this out. I can correct that" or words to that effect. She offered to write the letter and asked what she should say. Dr Berry said he did not stay in the room while she wrote it, so joined her husband in the adjoining room (he having left to take a telephone call on Donna Rule's account).

192. Dr Berry said it was not typed and he did not put her under pressure to write the letter. On the contrary she offered to write it. He said "at the time I did no realise she had given two statements to the PCT saying the opposite".

193. The accounts of the two witnesses could scarcely be more at variance. One of them was not telling us the truth.

194. Dr Berry then produced an analysis of the weight loss of his patients at D 11-13, and said he was proud of his achievements. At D14 was his further analysis for patients heights *estimated* by him, although when he saw the patients in consultation he could estimate it for himself. For this exercise he had the national average height. By this analysis over 90% were overweight or obese.

195. He conceded that if no weight was recorded it could be inferred that the weight was not done. As for blood pressure a lack of a note did not necessarily mean that it was not taken, but he might not have written it down if there was a normal pattern and there was no real need.

196. As for BMI, the lack of recording did not mean he was not interested in BMI: he had a ready reckoner for BMI.

197. Dr Berry referred to the document at D 18- 23 and said he had gone through the record cards to create this to indicate the number of entries made on the record card by the receptionist and the number made by him. This was intended to deal with the suggestion that Donna Rule was seeing patients on her own.

198. He said some record cards no longer existed. If patients had not attended for some time he would prune their records out. There were (he said) no regulations as to how long you have to keep records for private patients. So if he was doing some shredding of his bank statements he would shred the cards he had pruned out at the same time. In addition "some patients declined tablets and I tore up those cards at the outset.

199. If the receptionist did give out drugs at his request, Dr Berry said he would then want it to be in her handwriting as an alert to him.

200. Dr Berry was then asked about whose handwriting appeared on a number of patients' record cards, but in view of the agreed Schedule of identification of handwriting, R1, it is not necessary to set out that evidence at length. He continued that exercise when he resumed evidence the following day (the fifth of the hearing). Dr Berry explained in the course of this evidence that he kept the weighing scales under the couch in his room. He accepted that he was not at the clinic on 25 July 2005: there are seven patient entries for this date which he agrees are solely in Donna Rule's handwriting. However he said it was not true that she ever ran the clinic on her own.

201. Dr Berry denied he had ever approached Donna Rule in Tesco and said her account of such a meeting was totally made up. He recalled she said she would get a crime number but had heard nothing. He had made enquiries of the police and referred to D 425 and D 426 which indicated that Essex police held no personal data in relation to his request.

202. Dr Berry next produced two invoices for purchases of medication from Cambridge Healthcare and Essential Nutrition in 2005: D 351 and 352. These were the only records of drug purchases we have seen. However, in the photocopies within his bundle Dr Berry had blanked out both the quantities of tablets purchased and the total price. All these documents told us was the unit price. It was not clear why he had chosen to do that.

203. Dr Berry next produced a letter from his accountants dated 14 November 2007 which set the slimming clinic income rather higher than the figures he had originally given us: £5400 for year 2004/5; £8,445 for 2005/6 after deducting £4045 refunded to NHS patients; and £1480 for 2006/7 (two months only until it closed). The source of the underlying information was not indicated.

204. He also produced a specimen diet sheet of the kind he had handed out: D 471. He referred to a response form from the Healthcare Commission (dated 1 October 2007) regarding the status of private slimming clinics. We did not find a lot of help from that, as it stated the obvious that if an organisation is not listed that indicates they are exempt from registration of are operating a service that has not come to their attention.

205. He produced various documents to support his contention that other clinics were operating similarly to his own, in terms of the tablets they used. He also referred to a document emanating from the Medicines Control Agency summarising the adverse reaction of the different drugs: D 307 – 346.

206. He said that he had now established that phentermine and diethylpropion were prescribable on the NHS but because they don't appear in MIMMS or BNF every doctor thinks they are not available.

207. Dr Berry had had no idea what a named patient basis for supplying drugs was until the drug company told him. He understood from them that as long as he recorded the names of the patients he had given them to, and what he had given, that was enough to satisfy the named patient basis for prescribing.

208. He then produced D 166 a printed pack insert for Ionamin (phentermine) which he gave to patients with the tablets. When he wrote "leaflet" on the records it was this leaflet he had given to patients.

209. Dr Berry was asked about the "slimming down" of the record cards. He said he only ever had one box and he pruned it when it filled up.

210. If he returned to practice he would no want to be involved in running a private slimming clinic but would like to be involved in NHS management of obese patients. He had returned money to his NHS patients "because it was deemed incorrect that I should have taken money". Initially he returned the registration fee and then the cost of the drugs in two instalments. He referred to D 347 – 8, which is a list of 26 patients, 21 of whom have signed by way of acknowledgment of receipt of a "full refund" although the amounts were not disclosed on that document. In the other five cases Dr Berry wrote "cheque sent". He said he went and visited the patients to make the refunds.

211. Dr Berry went on to address Christine Ford's evidence. He said where there were repeat prescriptions for the nursing home she was copying his signature.

212. Lastly Dr Berry addressed the matters arising from the alleged harassment of Mrs DL. He first described her husband's illness and death and his role in trying to alleviate the family's suffering. DL had left a copy of the Daily Mail for October 30th 2007 at his house together with a note saying: "might be of interest page 37". He said he had known them for several years really well and also knew her father at the tennis club. He did ask her out after her husband's death. He said: "She went a touch red and said she would need to make arrangements for he boy but I said it was nothing like that and bring him along and I'll bring mine". If there had been any interest on her part he was going to ring the GMC and check what was allowed. However he got a letter several days later as on pages 509-510 and she was obviously embarrassed so Dr Berry was sorry to have caused it and therefore did no see her again other than to hand her a letter of apology (page 511).

213. The letter at page D10 which he now produced was brought around or put through his letter box. He then took it to his then solicitors Edwards Duthie. He said the sequence was that he got the original through his letter box and faxed it to his solicitors and then he took a copy with him to see his solicitor who then wrote the letter of 30 July 2007 to Mrs DL, which is at D 439. That letter says it would be helpful to Dr Berry if she could send her letter to Karen Leese at the PCT. However the suspension hearing in front of the Interim Orders Panel of the GMC was imminent on 2 August and he did not have time to go back home for the original. So far as we can establish none of the various photocopies we have seen in this appeal hearing is the original.

214. Dr Berry was cross examined by Mr Booth for the PCT. He was challenged that he had told many lies. The first matter (going to credit) was as to whether he had gone on holiday to the Isle of Wight with the Shiakallis family; Dr Berry had previously (at the hearing before the PCT) answered that question "no". In fact documents at C 1404 and following show that he arrived at the hotel one day after the Shiakallises and left one day later after three night stay in April 2003. He said his earlier answer had not been a lie and he had simply taken issue with the word "with", because it was a complete coincidence that they were there at the same time. He could not remember Mr Shiakallis telling him about his own plans to go there on the occasion when he picked him up from Heathrow Airport, and indeed could not remember Mr Shiakallis picking him up from Heathrow as Mr Shiakallis had alleged [see para 78 above].

215. Dr Berry was asked how it was that Ms DL had come to write the letter he had produced at D10. He said "you will have to ask her". He said he had not seen or spoken to her since he had handed her the letter of apology 18 months earlier. He thought is was wise to keep his distance, although he thought he might have emailed her after she dropped in a note about a clinical negligence claim concerning her husband, which had her email address on it. The timing of the arrival of this letter [D10] did not have anything to do with the imminent hearing in front of the Interim Orders Panel of the GMC, but he thought he could take advantage of its arrival to use it at that hearing. When asked about what steps he had taken to obtain GMC guidance when he was considering asking her out, he said he had contacted the GMC by telephone and the person he spoke to directed him to their website, which (he suggested) said it was "fine so long as nobody complains or minds".

216. Dr Berry was taken to the PCT file on this matter and the file note created by Karen Leese. He agreed that the file note only reflects a complaint by DL about being asked out, but her letter at D10 also deals with a suggested complaint that Dr Berry had been talking about the death of her husband (his former patient). He also agreed that the last sentence, "I do not want the PCT to contact me any more" was directed to the PCT (indeed the letter is addressed to Karen Leese) and there was no point in sending it just to Dr Berry. He said DL must have taken a photocopy of the original before putting it through his door and then delayed a further 12 days before posting it to the PCT. He then retracted that and said she was sent a copy of the letter by his own solicitor and then posted it to the PCT.

217. Asked further about how the letter came to be written, Dr Berry agreed he knew DL's mother well, and had mentioned to her that he could be helped if DL said he did not harass her. He said this lady has a neighbour who is a childminder he knew (and had used in the past). He mentioned to her it would be helpful if she could contact DL. He was reminded that he had said in evidence that he had not been in contact with DL and said he did not think it was lying as he had not approached her himself. He could only give a first name (Gladys) for

the childminder and said she lived in a particular block at Nine Fields but he could not otherwise provide the address, although he could go there. He "might have gone to see her". The message he had passed to DL was about a couple of months before the letter she wrote dated 25 July 2007. He had told the childminder that he had got into trouble with the PCT because DL was accusing him of harassing her and it was ridiculous, so if she agreed it would be helpful if she wrote to them. The childminder had written down this message for DL but he could not remember if he had dictated it, but he acknowledged that the sentence which reads "I wish to state that Dr Berry has never harassed me" was his words. He agreed he must have supplied the name of Karen Leese. Later in his evidence he was asked if he could produce Gladys's address the following day. He said he could. The following day he told us that Gladys lived at 4 Hayward Court while DL's mother lived at 7 Hayward Court.

218. This evidence and the way that the truth, or something closer to the truth emerged, was powerful. Dr Berry appeared on this and other issues to shift his ground to suit the circumstances. It is necessary to observe that at times it became difficult to make a coherent note of Dr Berry's evidence as he started and restarted replies changed his mind or contradicted himself.

219. Dr Berry was next asked about the destruction of the records of slimming patients. He said he kept a shredder at the surgery. He had last destroyed patients' records some time between Christmas 2005 and Easter 2006. He later said that he would have a shredding afternoon about twice a year. He was asked about some named patients who, it was put, had been slimming patients but for whom there was no record card disclosed by Dr Berry. These names were taken from a list of 72 patients whose names appeared in a diary of appointments for the slimming clinic [C 1336 – 1395] covering the period 15 November 2004 to 31 December 2005 and listed out at C 1396-1399, but for whom no record card had been provided by Dr Berry. He said the diary was kept by the receptionist and he did not touch it. He also agreed that the receptionist (Donna Rule) had given timed appointments at intervals of 5 minutes.

a. EK – Dr Berry said she was an NHS patient and (when it was put that she had attended the slimming clinic 11 times between November 2004 and November 2005) "maybe in the past a slimming patient". He said her record card might have been mislaid or misfiled. He did not suggest this would have been an appropriate card to have been shredded. He had not refunded her any money.
b. SC – he did not recall her, although he agreed the diary showed she had attended on 67 occasions between December 2004 and December 2005. He pointed out that these were diary entries and the patient may not have attended.
c. LS [C 1396] – was a private patient. She had 6 appointments in the first half of 2005 according to the diary, but no record card. He did not know why this was the case. He said the record cards "were kept in my room and when I started the clinic I took the cards out and afterwards [the receptionist] would put them back, but often they were missing or misfiled.
d. JC – the diary recorded 11 appointments for her during that period and he had no explanation for why there was no record card. He might have thought she was not coming back and there was therefore no point in keeping the record.
e. JL – the diary recorded 16 appointments between January and August 2005. She attended with her daughter NL, but there was no record card for either of them. He did remember them and that they stopped coming because they said they found it too expensive. He went to see them two days before they gave a letter which is at D 459 (dated 24 January 2008). He knew their address because they were patients for years. At the time he did that, he also refunded money to them. If they were not coming he thought he must have destroyed these cards, and that may have been two or three months after their last visit in August 2005.
f. SH – he remembered her as a NHS patient but did not know where she lived so could not get hold of her. He offered no explanation for a missing record card other than the generic one offered above.

g. AC – Dr Berry agreed she had had 10 appointments in the spring of 2005 yet there was no record card. He could not remember if she had a large waist, and had no idea where the record card had got to.
h. ZB had 7 bookings in the diary and Dr Berry said two of these were DNA (did not attend). He had no idea where her record card had got to.
i. CH – 9 appointments in 2005 but no record card. However he referred to his analysis on page D 449 and said she only turned up on 4 occasions. Moreover the receptionist may not have crossed her off on each occasion when she did not turn up.
j. EL – 8 appointments, of which he had crossed off 3. He had no recollection of her and agreed there was no record card.
k. Mrs S [C 1402] he said made an attempt to come 5 times but only came once.

The next two patients were put to him at a later stage in his cross-examination:

l. HR – [C 1398] there were 8 appointments, 7 of which she had actually attended, the last being on 19 December 2005
m. SW – [C 1398] 9 appointments but only 4 attendances in the summer of 2005 and the last one of which was 5 December 2005.

220. Dr Berry drew our attention to his analysis of patients at D 452-453. He had identified 11 patients who, he contended, had made more than 2 visits but for whom there was no record card. However he could not say why he had not included the patients Mr Booth had put to him (paragraph 219 above). If there was only a one-off attendance, he would destroy the record card. Asked about taking the cards home to his garage (Donna Rule's evidence having been that he invited her to his garage to sort through patient record cards) he said he might have taken the record cards home with him from time to time "to tidy them up or to prune them". He last took them home when he was suspended, but denied asking Donna Rule to come round and help sort them out. He had only asked her to help compile the list of patients he had to produce, as she was the only one involved with the slimming clinic. It was just an hour or so after he left the surgery. He did not ask her to come to his house.

221. Dr Berry said he took at the most, all the record cards for 2005 and the last 2 months of 2004, that was a maximum of 60 cards and would easily fit into the box he had. However he agreed there were cards in the bundle he had produced which went back further than November 2004. It was put to him that Jan Hutton had said there were originally 3 boxes of cards (which he denied) and that the evidence of Christine Ford that there were 2 boxes of cards was unchallenged. He said it was not him cross-examining but there was "never more than one box".

222. Dr Berry was asked about some occasions when it was suggested that either Jan Hutton or Donna Rule had written the notes appearing on the record cards of patients. He was taken to the record of AB [patient number P7] whose notes appear beginning on page B 612. On page B 613 Jan Hutton wrote the note dated 8 April 2002 (he agreed) and recorded the patient's weight and that she had given the patient Ionamin (phentermine) medication for 14 days. The last blood pressure readings prior to that were on 4 March 2002 and no blood pressure was taken after that until her next visit on 17 September 2002. Dr Berry agreed that he had said neither Jan nor Donna ever rang him to ask about handing out medication. It was a drop-in clinic so he had no way of knowing who would turn up. He agreed that both Jan and Donna had said they never weighed the patient if he was present. However he said it was totally incorrect that he just said to hand out tablets if the patients had had them before. He said "These are not sick people. If I know them I can authorise them over the phone". He was asked about a number of occasions when AB had attended and been seen by him but he had not recorded her blood pressure. He said it was only necessary once a month but agreed that a 6 week gap which was pointed out to him should have occasioned a blood pressure record. He should have done it, although he said "it is not something that is going up and down like a yo-yo".

223. Dr Berry agreed that the last attendance by patient AB was 7 April 2003, yet her record card had not been culled when he weeded out the record cards of those who had stopped coming. He said he had given her "the benefit of the doubt" because she had been on many occasions in the past.

224. It was put to Dr Berry that he took home 2 boxes of record cards to weed out in May 2006 but he denied it and said only 60 more record cards would account for the extra patients in 2004-05, and they would fit into the existing box.

225. Dr Berry agreed that his slimming clinic was getting busier and he had talked to Donna about doing a Saturday in the community hall. He acknowledged his accountants' figures for 2005-06 suggested over £12,000 income but could not produce any further documents to show how that was calculated, as it was a figure in his tax return but his accountants had copies of the documents and he did not keep them. He said "I shred my bank statements". He offered no explanation as to why he did that. He said he could not agree or disagree with the suggestion that he had seen 600 -750 patients over the time he ran the clinic. The details of the last two patients listed at paragraph 219 above were put to him (showing appointments up to and including December 2005) and he was asked about what happened when he took the record cards home. He said he had nothing to hide. What he had been trying to say to Christine Ford was that they must not think there was anything being hidden because all the cards were there. On the cards we have, he said he used a red pen a lot, to alert himself routinely to medical problems. He rejected any suggestion that he had added entries in red at a later time.

226. Following a break in his evidence Dr Berry was asked if he agreed that a GP who is fundamentally dishonest is unsuitable to be a GP on the Performers List. He replied "Yes, obviously". He further agreed that leaving an unqualified receptionist to give out drugs on her own would make a doctor guilty of unacceptable practice.

227. Dr Berry said he was rarely away from the practice but on 5 or 6 occasions a year he would leave early. This was mostly in winter, not summer as suggested. He would not know who attended the clinic after his departure. If someone turned up the receptionist was supposed to ring him but he agreed this had not happened many times over the years.

228. Dr Berry agreed that on 25 July 2005 6 patients were seen by Donna Rule on her own. No phone call was made to him. However he said there was no clinic as such because these patients just needed to collect a 2 week supply. He denied that if the patient had had tablets before, he was content for the receptionist: she had no business weighing the patient. He was asked by the Panel what he therefore thought when he saw on the record card that the receptionist had been weighing the patient. He then said that sometimes he did ask the receptionist to weigh the patient because he was interested to know how they were getting on.

229. Dr Berry was asked further about his entries in red pen on the record cards. He said it was to highlight problems or that a leaflet was given out. He said in the 48 hours these cards were in his possession in May 2006 he had not added anything to them. It was pointed out to him that on 8 May 2006 (shortly before the slimming clinic ceased to operate) he wrote on 28 patient record cards in red ink. He was asked why he had made so many entries in red on that date. He said "Because if there is a policeman watching your driving you are extra careful". He denied using a red pen to add words such as "leaflet" on 8 May. He said he had sometimes added the word "leaflet" to show he had given it later. He said he would always explain side-effects verbally on the first attendance, but if he were in doubt whether they had understood he would give a leaflet as well.

230. He explained that on a first visit the receptionist wrote "SE" standing for side-effects as one of the headings under which he could record information. He agreed that in the vast majority of cases this was left blank and there was no tick to indicate an explanation had been given, as there was under other headings. His explanation for this was that he had stopped writing it down (or ticking it) because he knew it was something he would always do.

231. By reference to colour copies of the patient record cards, Dr Berry was asked about some further patient record entries:

   a. DAL – [patient P3 at B 602] he had written the words "to pay" in red and also the cross over that. There was no entry next to the heading for side-effects and no note of a leaflet given. However he would have discussed them in full. There was no advice about alcohol recorded but he would have done so because he needed to tell the patient that it contributed to weight [we noted that the leaflets for these two drugs advised that alcohol should not be taken with them]. Dr Berry had not advised

abstention from alcohol and thought that advice would be in the leaflet but agreed if they did not get the leaflet the patients would not know to avoid alcohol. On 2 April 2006 the entry was in Donna Rule's handwriting. On 15 May 2006 blood pressure was noted and then a list of side effects signed by the patient.

b. AA – [patient P4 at B 605] came once in 2001 and not again until 2004. Dr Berry agreed there was no reason not to cull this card from the records in between those two dates, on the criteria he had suggested. He must have thought she would come back. He said that the earlier entries, from 1996, showed he then kept fuller notes but had later developed a writing problem, except that when we come to May 2006 he made much fuller notes again, for the reasons previously mentioned [the "watching policemen"]. He had put red circles around her slightly raised blood pressure but she was nearly 18 stones and there was only mild hypertension and medication was not contraindicated. On 9 November 2004 he agreed the notes indicated he had left a supply of 14 days' phentermine to be collected in his absence, despite the slightly raised blood pressure. He agreed he should have seen the patient and taken her blood pressure and weight before supplying her with tablets. On the next occasion (6 December) he had again given her drugs without recording her blood pressure, but thought it probably was taken (albeit not recorded). He agreed perhaps "with hindsight" he should have re-done her blood pressure.

c. HA – [patient P5 at page C 607-08]: her first attendance was 11 October 2004 and there were no details recorded against "SE" but on 9 November the word "leaflet" was written in the left hand margin under the date. Dr Berry said that is when the leaflet was in fact given. He agreed that on all 9 occasions when blood pressure was recorded it was 120/80. He thought that was not unusual in a young healthy person, although he agreed that if you rechecked the same patient's blood pressure on the same day it was unlikely you would get identical values. He thought he had been rounding blood pressure readings to the nearest 5 but Dr Shutkever thought he was doing it to the nearest 10. He rejected any suggestion that he had conventionally inserted a safe blood pressure figure without properly recording the blood pressure.

232. Dr Berry was taken to the specific allegations in this case. He agreed he did not record BMI but he looked at his ready reckoner on the first visit. He noted the patient's height "only when I thought she was too tall or too short". He denied that it was his practice to continue giving medication until they reached their ideal weight. He denied there was no specific goal in mind. His purpose was to reduce them from obese. He did not mark any ideal weight or target for the patients.

233. He agreed that a lot of the documents produced by him were to the effect that waist measurements were more important than BMI but he was not saying that represented his practice. He agreed he did not take waist measurements. He only asked that if the patient was clearly not overweight and he would otherwise have declined to give medication, but the patient had insisted because their belly size was too great, then he would ask what was their belt size (which he said would be 32 for women or 34 for men). Some patients did make out a case on their belly size.

234. Dr Berry was asked about his prescribing drugs in relation to the BMI of certain patients:

a. VB – [patient P16 page B 634]. This relates to allegations (ii) and (iii) (failing to obtain BMI and inappropriate supply of slimming drugs, both before and after he recorded her height). He conceded that no BMI was recorded but he would have asked her what was her height. He did not record it at first but did so later because she asked Dr Berry what was her ideal weight. He had not memorised it from her first attendance so would not have known it when he later came to advise. On the basis of that height later recorded on 1 September 2003 her BMI was only 21 or 22, but he thought it was not at the outset. He did not accept that it was inappropriate to give medication to her on and after 1 September 2003. He agreed that the word "leaflet" looked as though it had been over-written on the stamped date on 6 October 2003.

b. KB – [patient P 9 who gave evidence to us, record card at B 619]. This related to allegation (iv) in the list of charges against Dr Berry (supplying the slimming drugs when it was inappropriate to do so because she did not meet the criteria for anti-

obesity medication). Applying her weight to the charts made her BMI 30. Dr Berry's position was that it was OK to give medication if the BMI was 29 or 30 but also if it was 22. He had not given this patient special treatment because she worked for Pfizer. However he agreed with Mr Booth that it was not appropriate to give her the medication if she attended on the first occasion with a healthy BMI.

c. TB – [patient P 28 whose record card is at B 658]. This related to allegation (v) in the list of charges: inappropriate supply of slimming drugs. It was put to Dr Berry that on five dates he supplied phentermine when her BMI was in the range 25-27. He said his position was that it was OK to give the medication because she was overweight, and he regarded this as anti-overweight medication, not anti-obesity medication. He explained that the letter P noted on page B 659 usually meant that the patient picked up the tablets but was not seen. He agreed it was in fact a further 6 months before she had her weight or blood pressure checked.
d. CC – [patient P56 whose record card is at B 715]. This relates to allegation (vi): inappropriate supply of slimming drugs. Dr Berry agreed her BMI was in the range 25-36 but maintained it was still alright to give medication. Her height (5 ' 8") had in fact been recorded on the first occasion she attended. He agreed he did not always do so.
e. CF – [patient P 92 whose record card is at B 793]. This related to allegation (vii): inappropriate supply of slimming drugs. He said he believed he estimated her BMI to be 25. He denied that was healthy and said it was overweight. Professor Wilding had calculated the BMI to be 24 but if it was 25 as he believed she was overweight. It was a single visit only. He supplied Ionamin (phentermine) for 14 days. He said he was happy to help if they had tried all other measures. He always asked what they had tried and what they wanted. He was shown the originals of her records which show entries in colour [pp 235 -6 of colour copy bundle] and said he had not filled in the words "leaflet" and "C/I" in red when he knew he was being investigated.
f. JH – [patient P 132] This relates to allegation (viii): inappropriate supply of slimming drugs. Dr Berry asserted this patient was overweight despite having a BMI of 25. He noted that she had also attended a clinic at Waltham Cross which had helped.
g. LL – patient P 169 whose record card is at B 959. This relates to allegation (ix): inappropriate supply of phentermine. He agreed he had supplied phentermine despite a BMI which (it was put to him) was 23. However he said that he remembered this patient because she had a raised waist measurement, although she only attended once on 21 September 2005. It was put to him that if his explanation for culling record cards was true, he would have culled this one. He did not know why it had been overlooked. This patient had written a letter on his behalf, which he explained had been done at his request. He had not asked her to say anything other than the reason for having the tablets. He said "I accept this was inappropriate strictly on the BMI but she said she was a 34" waist – she made a case for herself. I did not make a note of her waist size [on her card]". He accepted she was not overweight.
h. LM – patient P 181 whose record card is at B 983. This relates to allegation (x): inappropriate supply of slimming drugs. Dr Berry thought she may have been obese. He calculated a BMI of 31. When her weight reduced to 10 stone 7 lbs [noted at B 984] her BMI was then 27 but he would not have checked the BMI on a subsequent occasion. He confirmed that the entry on 16 June 2003 was all in Jan Hutton's handwriting and that the patient did not attend again for another 4 months after that.
i. CS – patient P233 whose record card is at C 1089. This relates to allegation (xi), that he had supplied slimming drugs inappropriately. She was 17 at the time. Dr Berry could not remember what steps this patient had taken to lose weight. He said that she had made a case for herself and lifted her clothing to show a protruding belly. This patient was one of those who had provided a letter. Dr Berry said that he did ring her to ask her to recall that she had shown him her belly and to provide a letter to corroborate that. He conceded that there was no reference to pregnancy being contraindicated in this 17 year old but was sure he would have told her. He said he did not want to give her medication and the patient would say that. She was working

as a beautician and was keen to get the medication. He agreed that the supply of medication was written on the card before the note of a diet sheet, and also agreed that counselling would be important for a 17 year old living alone. He repeated that he did not want to give her medication but she had made a case based on her waist size. There was no note of her receiving a leaflet (about side effects) but he said all patients got them. Dr Berry accepted in conclusion that he should have been more thorough with this patient and resistant to her wish to get medication.

j. KB – patient N 4 whose record card is at B 537. This relates to allegation (xii): inappropriate supply of slimming drugs. She was one of his NHS patients who attended on one occasion on 23 March 2004. He was asked why this record had not been culled if he had used the criteria he said was the explanation for culling cards. He said it was not a precise exercise. Her BMI was in his view 30, not 29 (as the PCT contended). He had recorded a height of 5 foot 1 inch, and when asked about the position of this note on the page he said he wrote it himself just anywhere and not necessarily on the next line after the weight.

235. Dr Berry was asked about charging his NHS patients for the slimming clinic registration and supply of medication. Charing for registering at the clinic is allegation (xiii). He said he charged some but not all of them, and everyone had been refunded since his suspension in 2 or 3 instalments. Everybody was treated as a private patient. He conceded he should not have charged them anything. He said he had put a red cross through the names of some of the 25 NHS patients to show they were refunded. As to charging for supply of medication (allegation (xiv)), he did not admit that he had done so, knowing that it was not permitted, because he contended that the only way he could have given those drugs was to write a private prescription. At no time did he know he could have prescribed them on the NHS. He said "I just should not have seen these NHS patients" and it followed that in that sense it was wrong to charge them for the supply.

236. Dr Berry was asked about prescribing or supplying drugs without an appropriate examination: allegation (xv). He said the three NHS patients identified in that allegation were well known to him. That was why he had not recorded a history for patient N 18. He also denied that it was inappropriate not to do an examination, since he used to examine them in his NHS surgery. He agreed that he had not noted a history or any findings (including blood pressure) for patient N 20 and had not recorded a blood pressure over 2 years. He agreed that patient N 22's card showed no record of history or an examination. In relation to patient N 18 he knew her to have health problems and she worked as a nurse. He agreed that the record card entries for 17 July 2001 (B 579), 17 December 2002 and 29 July 2003 (B 580) were entirely in Jan Hutton's handwriting, consisting on the first occasion of a weight record and note of the medication supplied, and on the other occasions just the medication supplied. He agreed that on 28 July 2004 the record was entirely in Donna Rule's handwriting (both weight and medication). Lastly he agreed that on 9 May 2006 (B 577), between the first and second visits by the PCT, there is an extensive note as to advice given to patient N18:

> "S/e [side effects] explained. Pulm [pulmonary] Hypertension, addiction, palpitations.
> Advised tabs not appropriate for her weight. Insists.
> Received leaflet."

There is then a note of her blood pressure and weight (11 stone 5 lbs).

237. Allegations (xvi) and (xvii) related to Dr Berry's failure to inform the GP with whom patients were registered that he was treating them, or to advise those patients he was expected to inform their own doctor and to record their refusal if this was the case. Dr Berry said when he first started the clinic he used to ask if they wanted their GP informed. No patient ever agreed. He said "I wouldn't say that practice died out. I may have missed one or two". He claimed that he did tell several patients they should go back and see their own GP, but he had never recorded a patient's refusal to contact their GP. He agreed with Mr Booth that as a GP he would want to know if someone was giving his patient a Schedule III drug, but that was a matter for the patient. He denied lying about asking patients for their permission to contact their own doctor.

238. Allegation 18 concerned his requiring unqualified practice staff to supply Schedule III controlled drugs to patients contrary to the requirements of the Misuse of Drugs Regulations

2001. Dr Berry accepted that he did require Jan Hutton and Donna Rule to supply such drugs on occasion, “but only after I had authorised them in every single case”. He said he had repeatedly told Mrs Hutton and Ms Rule to ring him if anyone walked in to the clinic [after his departure]. He had never said get on with it and deal with it. He was reminded that he had admitted leaving early on 5 -6 occasions a year and that on 25 July 2005 his own records showed that 6 patients had been seen in his absence. [In fact there is a 7th patient on that date whose record card is at C 1118]. He said his case was that in each and every case he had specifically authorised the drugs to be given by the receptionist. On some occasions he would have been present on the premises and would have been shown the care when perhaps the patient could not wait. He accepted that he had said earlier in his evidence that it is possible he was away on that date, but maintained he had seen other patients on 25 July 2005. His attention was drawn to some patients whose record cards showed they had been given drugs on that date but did not appear in the booking diary. He could not remember if he had left after 6 pm when a thick line appeared in the dairy. He

239. Dr Berry agreed that there was no written authorisation to his receptionist to give patients these drugs on any of the occasions when they were in fact supplied by the receptionist.

240. Dr Berry gave a number of alternative explanations, which amounted to surmise (as he could not specifically remember) why supplies of drugs of up to 3 weeks had been supplied by his receptionist to patients. These included the explanations set out at paragraph 238 above, patients reporting drugs stolen or lost and therefore needing a further supply, patients turning up to the clinic after he had left, and patient speaking to him by telephone to explain they were unable to turn up at the usual time and consequently his giving instructions to the receptionist to supply a further week or two to the particular patient when the patient was able to attend. He said if this could not be avoided he might write a note to the receptionist on a scrap of paper or just tell her orally. He said he had not previously told anyone about writing authorisations on scraps of paper “because you have not asked me”. This is one of the periods of his evidence when confusion and contradiction affected the cogency of his replies.

241. Dr Berry’s account of the role of his receptionists is at odds with the evidence of Jan Hutton and Donna Rule. He was asked if he could account for why they might wish to tell lies about him. He said “The receptionists are acting out the doctor fantasy; they are telling lies”. He said he could not explain the motive of Donna Rule. He had never seen her Tesco or discussed what evidence she would give. He speculated that Jan Hutton’s motive was “to do with Fred Short who blamed me for his wife’s death”. He also said “She is trying to put me down. She also claims I failed to look after Mrs C’s mother”.

242. Dr Berry said he had reflected on his actions but did not accept they were inappropriate. It was OK (he believed) to leave early if it was a quiet clinic.

243. Allegation (ixx) concerns prescribing phentermine and diethylpropion privately to NHS and private patients when he knew or should have known that they were available to be prescribed on the NHS. He said he used these drugs because he was familiar with them, but did not think they were available on the NHS, a mistaken view which was shared by others. He looked in BNF and Mimms but had made no specific enquiries as to whether they were available on the NHS.

244. Allegation (xx) concerns supplying these two drugs during periods when they were not in fact licensed to be supplied. He said he had stopped for a little while when he got a leaflet saying they had been withdrawn by the MHRA, but then he continued to give the as off-licence drugs, and made the patient aware of the position. He agreed however that he had made no record of any occasion when he advised patients that the drugs were not licensed. He said he did check of alternatives (such as those mentioned by Professor Wilding) were available but did not record in the patient’s notes the reason for choosing the drugs he in fact supplied.

245. Allegation (xxi) concerns Dr Berry’s supplying phentermine and diethylpropion after their licences were reinstated but when (it is alleged) it was inappropriate to do so because they were not recommended by the Royal College of Physicians or BNF. Dr Berry said he could not remember whether they were recommended or not. He acknowledged they disappeared from the BNF but he knew the drugs so well and felt very comfortable with them.

246. Allegation (xiiii) is to the effect that he dispensed these two drugs for NHS patients when his practice was not approved for dispensing. He said he did not dispense NHS drugs to NHS patients. The drugs he used were not NHS drugs in his view.

247. Allegation (xxiv) concerns Dr Berry's alleged inappropriate use of Schedule III drugs as a first line of treatment. He did not accept he had done so: "these people are coming to my slimming clinic having tried other things first". He conceded that "the vast majority of patients who registered were given drugs" but that was because they were overweight. He maintained he had to be satisfied they had tried other things first such as GP clinics, or weight watchers.

248. Allegation (xxv) concerned his failure to take blood pressures correctly or at all, before giving medication. Dr Berry conceded that it was an absolute requirement to take blood pressure at the start and regularly thereafter, but not on each visit. He did not accept the thrust of the allegation and said he considered taking blood pressure at monthly intervals adequate. He said in the vast majority of cases where there had been a long break since last taking tablets, it was not necessary to take it again.

249. (xxvi) alleged that Dr Berry had falsified his patients' slimming records by entering blood pressure recordings when he had not in fact taken their blood pressure. He agreed that the figures "120/80" appeared very frequently. He said he rounded them up or down to the nearest 5 but it was possible it was to the nearest 10 [this was what his own expert said]. We had previously seen a number of record cards on which the blood pressure is the same figure on many successive visits. By way of example it was put to Dr Berry that the record card for patient P8 [B 615] shows a figure of 120/80 on 7 out of 10 attendances at the slimming clinic from 1998 to 2000 and again on 5 out of 7 attendances where there is a record at all, from 2001 to 2005.

250. Allegation (xxvii) is in similar terms but concerns a failure to do or record a physical examination before determining the treatment. Dr Berry maintained that there was "physical examination appropriate to a private slimming clinic: blood pressure, pulse and weight". He agreed he did no record the pulse, and that nowhere in the records was there any reference to tachycardia [a risk associated with these drugs]. He did remember one patient who did develop tachycardia and he referred him to his GP.

251. As to allegation (xxviii) (failure to seek other complications of obesity such as diabetes, sleep apnoea, dyslipidaemia) he agreed he had no tested for dyslipidaemia which he thought was not appropriate. He would have asked about symptoms of diabetes when he first saw the patient; "whether weeing a lot or thirsty". He always asked if they were well or had any symptoms. He did not ask if there was a family history of diabetes. He was aware that increased waist measurement was associated with an increased risk of diabetes, but said there were times when he said "I cannot treat you; you should go and see your own GP". Another patient had come in with depression but he was satisfied this was no down to the tablets.

252. As to allegation (xxix) (bullying his patients to lose weight) we were referred to Dr Berry's evidence to the PCT.

253. (xxx) alleged that Dr Berry had issued slimming medication to patients irrespective of whether they had lost weight, or were obese, and without regard to blood pressure. His response was to refer to the analysis he had prepared at D 25-26, which he said were examples of good medical practice to be found in the record cards. These were 16 patients where there were instances of not giving tablets on each visit, or advice to tail off the dosage, and in two cases advising the patient to see their own GP. He said the other 280 patients whose record cards were available were healthy patients with no problems.

254. Dr Berry was taken through the records of a number of patients (M3, N5, N8, P15, P61, P128) where he had supplied or continued to supply tablets when there were (it was suggested) good reasons not to do so, such as a radical weight loss achieved, a blood pressure of 150/80 or (in another case) of 90/70 coupled with a weight down to 9 stone 6 lbs, or other low weight patients. He accepted that patient P15 was one which "slipped through the net" and it was wrong to give her tablets. His comments about other patients were either that it was just something to keep an eye on, or that the patient may have been overweight. In relation to patient P61 he said it was acceptable to continue to give tablets when she had lost 7 lbs in a week in case she put it back on.

255. As to allegation (xxxi) (inappropriately continuing to prescribe these drugs in excess of the recommended 3 months) Dr Berry did not believe that anybody had had them for a continuous 3 months: there had always been a break of some duration. He was asked to consider the example of Mr NE-D (patient N10: record at B 555-558). He agreed that there was a continuous supply to him for a period of some 4 ½ months from 1 March 2004 to 12 July 2004. He said there had been an astounding weight loss and you could not just stop suddenly. He then suggested the supply of tablets was not continuous but he and Counsel calculated that at least 112 tablets were supplied over that period. Nevertheless he said he had never had a case of dependency in his clinic, ever.

256. As to allegation (xxxii) (failing to explain the risks of side effects before prescribing these drugs) Dr Berry said he always did so although it was not his invariable practice to give patients a leaflet setting out the side effects on the first occasion they attended. He used the leaflet to reinforce at a later date the information he had given orally on the first occasion. Asked why he had not ticked or marked against "S/E" which was entered onto new patients' record cards by the receptionist, he said he used to write in detail but if he was tiring he might not have done.

257. Dr Berry denied allegation (xxxiii) on the basis that he was simply supplying the drugs and not prescribing them so was not required to record formally in words and figures the prescribed drugs.

258. Allegation (xxxiv) concerned his alleged failure to store diethylpropion in a locked receptacle to prevent unauthorised access, contrary to the Misuse of Drugs (Safe Custody) Regulations 1973. He referred to a copy photograph at page D 163 which showed a small safe apparently sitting on top of a cardboard box against the wall of his garage. He said it was in fact fixed to the wall. About 3 or 4 years ago he had wanted to get rid of a locking cupboard and get this safe to store his drugs. He had a DIY man fix it to the wall. He understood that the drugs had to be in a lockable receptacle, He only used the safe for storing phentermine and diethylpropion. He said that on the occasions when the receptionist was left to hand out the medication, these drugs would not have been locked up but just kept with her behind her desk.

259. Allegation (xxxv) was that Dr Berry had persistently prescribed these two drugs which he knew or ought to have known could create dependence. He was reminded of the evidence of Ms JH [patient N17, page B575] who had said she had been on slimming tablets most of her adult life. Dr Berry said that he thought she had told him that she had tried sibutramine (one of the drugs currently licensed for use) but "could not get on with it". He then said he was 100% certain of that. He said that she had reduced her weight from about 12 stone to 10 ½ stone and he was weaning her down, but she was desperate to get her weight down. He said "I knew these patients well and they were desperate in the sense that they were really keen".

260. Allegation (xxxvi) concerned Dr Berry's failure to provide evidence that he had retained invoices to the supply of the Schedule III drugs, contrary to Regulations. He said an order for drugs lasted him about 2 years. He ordered them on what he understood by a named patient basis, which he understood to mean that he simply had to record the name of those to whom he supplied tablets. He did not suggest that he had retained all the invoices.

261. (xxxvii) alleged that he had destroyed patient records without regard to complying with legislation governing the preservation and destruction of medical records and when he was no permitted to do so. Dr Berry said that he did destroy medical records from time to time. He "did not want to carry too many cards around. He said that there were no specific regulations about the keeping of private medical records. His understanding of his responsibility was that he should keep the record card if he felt the patient was likely to come back within a reasonable time. His only standard practice was that he removed some if the box got full, because that made it easier to avoid misfiling.

262. The allegation at (xxxviii) is that Dr Berry falsely informed the PCT and the PAG that he had supplied to them all the slimming clinic records that existed when he knew that was untrue. It was put to him that he could not explain what had happened to a large number of record cards. He said he may have been carrying information in his head to help him prepare his defence but there had never been more than one box of cards. It was not clear to us how this was relevant to the allegation. He could not remember when the cards were at his home,

or for how long. He responded to the allegation by suggesting that if he had really wanted to prune the records he would have removed all the low weight patients about whose treatment he was criticised.

263. The allegation at (xxxix) is that Dr Berry asked Donna Rule to assist him by supplying false evidence to the PCT, to the effect that he was always present at the slimming clinic, when in fact he was not. Although not limited to the occasion of his visit to Donna Rule's home, this episode was of major significance to the allegation. Dr Berry was asked about it. He said he knew Donna had had her baby because he got his mail forwarded and a staff member had written that information on it. He went with flowers and a note in his pocket. At that time he had not had the PAG report, he said, but knew what was he was suspected of. He had written a letter [A 271] saying that in 2005 "there was no occasion when the receptionist gave out the drugs at my request". Dr Berry repeated in substance the account given to us in his evidence in chief. He claimed it was a coincidence that it was only after her husband left the room that Donna offered to write the letter for him. He denied standing over her as she wrote it. He said the letter which he produced at D24 was not supplied initially by him. He had simply said the nurse practitioner had made the allegation and Donna said she could correct that. Dr Berry said her letter was not copied and said there were a number of mis-spellings in it. The reference in the letter to her being trained and supervised for this clinic by Dr Berry would have been a reference to staff meetings and greetings. She was also aware of the side effects.

264. Dr Berry agreed that it was untrue to state (as the letter did) that Donna "did not ever give these drugs out in his absence", as he had admitted in this hearing that receptionists had done so from time to time. However the assertion in Donna Rule's letter was consistent with the letter he had himself sent to the PCT [quoted at para 263 above]. He now accepted that that assertion [A 271] was untrue but he was trying to give an overall picture when he wrote it. As to his assertion that "all the clinics in 2004 were done by me", he accepted that he had had some holiday in that year and it was possible that he was not there every time.

265. Dr Berry said it was not true that he had suggested to Donna that it was she who would be in the firing line, and thought it may have been a misunderstanding. He probably said "obviously if you had been giving out the drugs in my absence as they are saying it would be a very serious matter and we would both be in trouble". He did not accept that he gave her the impression she would be in trouble.

266. Dr Berry was asked about the allegation at (xli) (harassing Mrs DL). He said he visited Tesco 2 or 3 times a week and she then worked there. He asked her for "a meet". He telephoned her again but did not contact her. He got her telephone number from her medical records. The next day he received the letter from her through his letter box. He had then realised "this is horrible and she should not have said yes". Throughout this time she had remained his NHS patient.

267. As to allegation (xlii) he did not accept that there had been significant social contact with the Shiakallis family. He accepted that Mrs C and Mr Shiakallis were both saying that he had given out information that she was trying to conceive. However he said that he was simply mentioning in abstract terms that there was somebody "not far from here" who had had success tearing up charts and encouraging ovulation. Mr Shiakallis may have put two and two together to identify the patients. He denied saying that Mrs DL had tried to have a baby.

268. As to allegation (xliv) Dr Berry said he knew that "pp" signatures were not acceptable on prescriptions and told Christine Ford to "just squiggle it".

269. Dr Berry said he had not told Christine Ford to look out for anything odd, but had had told her to look out for handwritten alterations on the prescriptions.

270. As to allegation (xlviii) Dr Berry did not accept he had been deliberately untruthful to the PCT: there were a number of respects particularised at that allegation in which it was said he had been untruthful.

271. Dr Berry accepted the allegation at (xlix) that he had used the "Lloyd George" cards, which were the property of the NHS, for his private patients' records, but did not agree that this amounted to attempted theft of the cards. (allegation l). In summary he did not agree he had failed to co-operate in the PAG investigation (li).

272. IN re-examination he was asked about a number of examples of handwriting so as to identify his own. The Schedules produced as R1 - 2 now deal with the identification of handwriting.

273. In answer to questions from the Panel Dr Berry conceded that his running of the slimming clinic probably did no represent good modern evidence-based medicine. He agreed that he must have rounded blood pressure readings up or down to the nearest 10. He would need 2 or 3 blood pressure readings to know if there was a problem so this level of inaccuracy on one reading did not concern him.

274. As to patient N17 [page B 575] Dr Berry agreed that under this patient's drug history shed was taking drugs because of a deranged thyroid function, but did not seem to have considered that her difficulty in losing weight might be because of her thyroid function. She was also his NHS patient and he said he therefore knew her blood profile and screen and did not need to arrange blood tests for thyroid function, although he would have advised this in some other cases. He said that he would not have given them medication if they could not reassure him that their thyroid function was normal. He had not specifically carried out tests to confirm what he said he had been told (but not noted).

275. Dr Berry was asked about patient N24 [B593] who had raised blood pressure and had antidepressant drugs and drugs for hypertension. He agreed that he had supplied this patient with 28 diethylpropion tablets. He conceded "there may be criticism in that respect". He told us she was a fairly new NHS patient: she took prothiadine and had a hugely stressful job but there was no active depression or ongoing psychiatric problem in his view. He said "I should have been a bit more vigilant but I did not think her actively depressed".

276. As to symptoms of pulmonary hypertension (one of the side effects of these two drugs listed in the literature) he said he could only think of breathlessness. He never asked about these symptoms and only asked if they were feeling well.

277. As to the arrangement he had with the nursing home Dr Berry told us that after ringing the BMA he charged a rate of £100 per patient per year. They were all his NHS patients and he did not enquire whether it was permissible to receive a retainer while they were his NHS patients.

278. As to notation he explained that "P" in the margin of the record card meant Prescription although doctors normally wrote RX if they meant prescription. He would only write Rx if he were treating somebody.

279. Asked how the receptionist would know he had pre-authorised pills to be given out to a patient who turned up when he was no available, Dr Berry said he told the receptionist this would happen and it might be up to two weeks in advance. He expected the receptionist to remember. If a patient turned up and said the doctor had said it was alright, he would expect the receptionist to remember and therefore be able to know if it was a patient for whom he had not said it would be alright to pick up pills. He agreed that (for example) 7 patients attending in his absence on 25 July 2005 was a lot of patients for the receptionist to remember. If he had written it down he would have given the note to the receptionist, and he might sometimes have done this.

280. As to the practice of culling record cards, he said it was not a long process and he would do it twice a year. The aim was not to create space in the box but just to clear out the cards of those who were not coming any more. He said he must have taken the cards home the Monday before the PCT visit, if he had no completed writing up the cards for filing. However "it was mainly filing not completing the record cards". Dr Berry told us that he had occasionally taken the cards home "to tidy them up if I had not written them properly". This happened 4 or 5 times a year. It was rare.

281. Dr Berry told us that in hindsight it was probably inappropriate to visit Donna Rule's house on 10 October 2006, given that he knew she was a key witness. He had not thought she might be embarrassed or upset to see him. He said "I did not think for a second she was going to be a witness against me".

282. In further questioning from Mr Booth Dr Berry agreed that on 22 May 2006 the slimming clinic was due to take place but at 1 o'clock he was served with the order of Mr Justice Jack and was visited by Catherine O'Connell of the PCT at 2.30 that afternoon. At that time the record cards were not in the surgery. He was going to bring them in from home that evening.

Consideration and Findings

283. It is necessary to make some observations about our view of some of the key witnesses. We were invited to find that Donna Rule was dishonest and unreliable. She was not wholly reliable in what she identified as her writing. The agreed identification of handwriting in schedule R1 falls some way short of number of entries originally identified as hers in her statement. We could see for ourselves that her handwritten figures could appear very similar to those written by Dr Berry. However, reliability in that sense is a different matter from deliberate dishonesty. Dr Berry's suggestion that the motive of Donna Rule and Jan Hutton in giving evidence was that they were "acting out the doctor fantasy" made absolutely no sense to us and merely underlined the difficulty he had in offering any credible explanation as to why they should both attend this hearing to tell lies about him, and moreover lies to a similar effect. There is no history of antagonism between them before the PCT investigation took place, and indeed Dr Berry initially sought Donna Rule's help in "sorting out" the record cards when he was served with the Court order. In our judgment Donna Rule was assertive, but made some reasonable concessions. She was not always reliable on detail, but was honest in the essentials of the account she gave. Because of our reservations about reliability, particularly about her handwritten entries in the records, we looked for supportive evidence elsewhere. On occasion this support was to be found in admissions made by Dr Berry; for example that he sometimes left the clinic early. In other respects it was to be found in the unchallenged evidence of Shelagh Byrne that Dr Berry had left Donna Rule on her own at the clinic on 2 May 2006, when the staff explained their understanding that he had gone to play tennis, and that Donna Rule told her she often ran the clinic on her own and showed her what she did (broadly as she subsequently explained to us). It was also to be found in the evidence of Jan Hutton, who told us that she had run the clinic on occasions when Dr Berry was not present because he was on holiday or playing tennis or cricket or needed to be with his children. She ran the clinic in the same way (weighing the patient, recording the weight and handing out a supply of tablets and taking their money) 5 or 6 times a year. We found Jan Hutton to be an impressive and honest witness, who was appropriately cautious when she was not sure of something. We accept her evidence.

284. It is not possible to consider the credibility of the witnesses who have given damaging evidence against Dr Berry in isolation. We have to assess the credibility of the account or denials given by Dr Berry. Sadly, we found Dr Berry to be unreliable, and dishonest when his own interest (or what he calculated was his own interest) was served by so doing. Sometimes his account started with a partial truth, such as the assertion that he had not gone to the Sandringham Hotel, Isle of Wight *with* the Shiakallis family. Only on examination did it become more and more difficult to maintain the fiction that his presence at the same time was coincidental. His account [paras 215-218 above] of how the letter to Karen Leese from Mrs DL came to be written, and delivered to Dr Berry's house, started with a disingenuous comment "you will have to ask her" calculated to suggest that he did not know the answer. In fact he knew very well. If we were to accept his final version given to us in evidence, he at least knew that he had sent a message to her via an intermediary that it would helpful to write to the PCT in certain terms. We cannot even be satisfied that this is the full truthful version, so tortuous was it to obtain even this concession. The episode illustrated for us that Dr Berry was willing and able to manipulate the evidence when it suited him. The most important factor for us in assessing Dr Berry's evidence was however his own demeanour in giving that evidence. We have already referred to the difficulty in making a coherent note of some of his replies when he was in difficulties. He did shift his ground. He did drift off into irrelevancy rather than answer a difficult question. When he was tackling the difficult issues on credibility, Dr Berry gabbled and became difficult to follow. This was not (in our judgment) a nervous reaction to being in front of us at all, since he was at other times capable of a very confident, fluent and coherent presentation. It was because he was in difficulties considering what answer he could credibly give.

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285. We considered the specific allegations in the groups set out at paragraph 29 of this decision: The first group we characterised as patient management.

a. Allegation (i). It is not denied that Dr Berry failed to record BMI for his slimming clinic patients. He says he obtained it by asking or estimating the height of the patient and checking against his ready reckoner. He points to the fact that patient KB says he discussed her BMI with her. If Dr Berry considered BMI important enough to calculate, even roughly, it was necessary to record it, as a benchmark for any future progress by the patient. There are no such records. Sometimes the patient's height is recorded. Dr Berry produced a lot of documentation designed to show that waist measurement was a more reliable indicator than BMI, but was not in fact using that yardstick himself, except when a patient who was otherwise not overweight or obese was able to persuade him to give her tablets by showing she had an overlarge waistline. We would find Dr Berry's account more plausible if there were any supportive records, or if there were more occasions when he had declined to supply pills, even to patients who were not overweight or significantly overweight. On the contrary, there are about 14 instances (identified in Schedule R 3) where medication was prescribed to patients who were not obese or overweight, even among the record cards we have seen. We did not find Dr Berry's evidence as to his practice of scrupulous questioning and estimation of BMI in every new patient convincing. We find that he probably did not obtain or calculate a BMI in the overwhelming majority of cases. We find allegation (i) proved. We should say that we would not wish to overemphasise the importance of obtaining a BMI on its own. The important thing is to have an objective measurement whether it is BMI or waist measurement which is part of a proper care plan. We saw no evidence of this.
b. A group of allegations (ii to xii) concerned prescribing slimming drugs to patients when, by reason of their BMI which he knew or ought to have known, Dr Berry should have know it was inappropriate to do so. The first was patient P 16 (Miss VB) and we considered the evidence given by Dr Berry at paragraph 234 above. Our impression was that Dr Berry did not regard the matter of BMI as important. He did not record her height at the outset (12 May 2003) but did at a later stage (1 September 2003) when she had specifically asked him what her ideal weight should be. We are satisfied that he did not calculate her BMI. Over the period recorded, this patient lose 25 lbs. Dr Berry supplied slimming medication to her form the outset and continued to supply it throughout. We find that it was inappropriate to do so and therefore allegation (ii) is proved. From the date we find a measured height, it is possible to calculate BMI retrospectively. It was between 22 and 26 after 1 September 2003. Even allowing a measure of flexible clinical judgement as to where obesity begins (see below) we find that it was inappropriate to supply medication during that period, in particular when her BMI was moving downwards, and we therefore find allegation (iii) proved. While we accept Professor Wilding's evidence as to what is conventionally regarded as the threshold for obesity (BMI > 30) and what represents good practice for considering medication in the management of obesity (> 30 BMI or > 28 if there is co-morbidity) we have adopted the view that a degree of flexibility is acceptable to allow for clinical judgement as to what is in the best interests of a particular patient. We therefore find proved allegations (vii), (viii), (ix) and (xi) where the BMI was far too low to justify supplying slimming medication. We do not find proved allegations (iv), (v), (vi), (x) and (xii).
c. Allegation (xv) concerns supplying drugs to 3 specific NHS patients without first carrying an examination. It is common ground that there is no record of an examination. Dr Berry says he did not need to do so because he knew the patients well as his NHS patients. This is nevertheless a departure from good practice when patients were presenting for help with a specific claimed condition, and we do not accept this as a sufficient reason for not examining them, particularly when the proposed medication had a potential for harm. The slimming clinic was an entirely paper-based record system, unlike the NHS practice, and there is no evidence of cross-referral to computerised records of a contemporaneous examination. We find allegation (xv) proved.

d. Allegations (xvi) and (xvii) concern Dr Berry's failure to inform the GPs of patients whom he was treating at his slimming clinic, or to inform those patients that he was expected to inform their GPs. There cannot be any factual dispute that no GP was informed that his patient was attending Dr Berry's slimming clinic. Dr Berry accepted he had never done so. His reason was that they did not want him to do so. Our attention was drawn to the fact that Dr Shutkever had said he had never been informed when his own patients had attended similar clinics. We accept that patients will sometimes, perhaps often, not want their GPs to know they are seeking slimming help elsewhere. However it was Dr Berry's case that he *always* asked the patients if he might notify their own doctor and that they always refused. We do not accept that this was his practice. At least four of the patients called to give evidence said they had never been asked, and if they had been asked would have had no objection to informing their GP. If there were occasions when a patient was advised of the importance of notifying her GP but refused, good practice would require Dr Berry to note that fact. On no occasion did he do so. It may be that Dr Berry formed the view in the early days of operating the clinic that most preferred their GP not to know, and therefore made that assumption. We find that allegation (xvi) is proved and that allegation (xvii) is proved to have occurred on numerous occasions, rather than the specific number of 272 occasions which appears in the PCT allegation. The mischief of a patient's usual GP not being aware she is taking this medication is (among other things) that he or she may not be aware that symptoms may be side effects of the medication rather than an underlying illness, or that drugs will be prescribed which are not recommended to be taken in conjunction with these slimming drugs. These are not simply theoretical possibilities; we saw examples of patients with thyroid problems or a history of depression.

e. Use of drugs:
    i. Allegation (xix) concerns supplying Schedule III drugs to NHS patients when they were available to be prescribed on the NHS, without so informing the patients. Dr Berry says he was unaware that this was the case. While it may be said there was a duty for him to make himself aware, the evidence before us is that this confusion was shared by many people, including the PCT's Assistant Director of Medicines Management, and we therefore do not find this allegation proved.
    ii. Allegations (xx) and (xxi) relate to supplying phentermine and diethylpropion during periods when there was either no licence or they were not recommended by the Royal College of Physicians or British National Formulary. The licensing position was very confused over the period and that confusion was initially shared by the PCT. It took the PCT some time to establish the correct position and even at the hearing Ms Tomkins deferred to Professor Wilding on the specific periods when licences were either in force or not. While we are left with the impression that Dr Berry continued supplying these drugs without any change in his practice over a period of 10 or 11 years, and was not responsive to notices about their licensed status, we do not find either of these allegations proved.
    iii. Allegation (xxiii) is that Dr Berry dispensed drugs to his own NHS patients when his practice was not approved for dispensing. We agree with Mr Jenkins' submission that this situation was not dispensing within the proper meaning of that term. While the whole arrangement for putting Schedule III drugs into the hands of patients was gimcrack and poorly controlled, we do not find that allegation (xxiii) is proved.
    iv. Allegation (xxiv) is that Dr Berry used medication as first line treatment without having taken a full history or given lifestyle advice. While there is some evidence from patients called for Dr Berry that he advised them on lifestyle and handed them a diet sheet, we find that the history taking was at best perfunctory and at worst non-existent. Insufficient time appears to

have been given to such advice. Certain basic enquiries and measurements must be taken. If, as was often the case, Dr Berry did not do so on the first occasion, he could not establish that medication was appropriate. Even if they were apparently overweight the history is important, as could be seen in the example of is own NHS patient [N17] who should have been re-checked to establish whether she had a normally active thyroid before prescribing slimming medication. The diet sheets were not produced to the PCT or to us until Dr Berry gave evidence. We found that surprising. However the striking feature of the patient care is that in the overwhelming majority of cases a patient who attended his slimming clinic left the first consultation with medication. It is difficult to reconcile this with a genuine approach to exhausting other strategies for weight loss before resorting to drugs. We accept the opinion of Professor Wilding that it is inappropriate, contrary to good medical practice and puts patients at risk. Even allowing for Dr Berry's point that many of these patients had tried other things before they eventually came to his clinic, we find that allegation (xxiv) is proved.

f. Failure to obtain data before supplying drugs:

   i. Allegation (xxv) concerns a failure to take, or accurately take, blood pressure prior to supplying slimming medication. Dr Berry's case was that he did take blood pressure but it was not necessary to do so more often than once a month. We are able to accept that general proposition but have been shown examples where the intervals were longer than that, and the evidence does not establish that blood pressure was taken regularly, merely opportunistically. It could go for 6 months without a recorded reading. However the blood pressure readings, rounded as they were to the nearest 10, were insufficiently accurate to leave repeat readings for that long. No expert endorsed a practice of rounding the readings to more than 5 mm. Dr Berry's recorded blood pressure readings were insufficiently accurate to give him any clinically reliable information about movement of blood pressure in the wrong direction. Moreover, there was ample evidence that supplies of drugs were given by pre-arrangement without any regard to whether blood pressure had been recorded.

   ii. Allegation (xxvii) is in similar terms so far as physical examination is concerned. Blood pressure monitoring is part of the physical examination and we refer to our findings above. Dr Berry acknowledged that pulse is also part of a competent physical examination and he said he always checked it. We do not accept that he did so. He never recorded it. We accept Mr Booth's point that it is surprising that no tachycardia was ever recorded, despite the "speed/buzz" side effect mentioned by some of the witnesses. Palpitation can also be a sign associated with thyroid dysfunction or heart disease. Breathlessness or palpitations should of themselves prompt an appropriate physical examination. There is insufficient evidence of Dr Berry performing appropriate physical examinations. We find allegation (xxvii) proved.

   iii. Allegation (xxviii) says Dr Berry did not seek other complications of obesity, such as diabetes, or sleep apnoea or dyslipidaemia. The risk of diabetes does not seem to have been anywhere near the forefront of Dr Berry's mind. There is nothing in the notes to indicate he tried to elicit such information or performed any investigation for it. We accept that for those patients registered with other GPs, it may not be appropriate for Dr Berry to conduct the investigations himself, but he should at least refer the patient back to their own GP and there is no recorded instance of this. Doing nothing is no an acceptable option. Even when the notes disclose a history of thyroid there was no appropriate follow-up examination or investigation. We find allegation (xxviii) proved.

g. Management of patients on drugs:

i. We find not proved the allegation (xxix) that Dr Berry bullied patients into losing weight.

ii. Allegation (xxx) says Dr Berry issued slimming medication to patients at most of his clinics, irrespective of whether they had lost weight, were obese and without regard to blood pressure, and in so doing his actions were inappropriate, contrary to good medical practice and placed his patients at risk. We have already found that on almost all patient visits (whether first or subsequent ones) slimming medication was supplied to them. We do find that continued supplies were made regardless of whether the patient had lost weight, so that a significant number of patients continued to receive these drugs when they were no longer obese or overweight. We also find that Dr Berry has continued to supply the drugs without regard to blood pressure. We reject Mr Jenkins' submission on this allegation that Dr Berry was exercising his clinical judgement. Allegation (xxx) is therefore proved.

iii. Allegation (xxxi) is to the effect that Dr Berry prescribed phentermine and diethylpropion to patients for periods in excess of the recommended 3 months. Dr Berry's case is that if there were periods of treatment longer than 3 months then there were breaks within that period. Dr Berry did appear to accept in evidence that if patients were doing well, and especially if they were losing lots of weight, he had supplied the drugs for more than 3 months, but clung to the assertion that there had been breaks in the continuity of clinic visits. We appreciate that 3 months is a recommendation (as this allegation asserts) and not an absolute. However we are satisfied that the effect of Dr Berry's pattern of supply was to expose patients to a period in excess of 3 months' use of the drugs. Sometimes the interruptions in continuity relied on by Dr Berry were very short indeed and could not be seriously regarded as a cessation of treatment by any reasonably careful doctor, alert to the welfare of his patients. Some of the patients from whom we heard told us that they had been taking slimming medication for many years and in one case for most of her adult life. There is no real indication in the records that Dr Berry took the issue of potential dependence on these drugs seriously. It is a well recognised risk that such patients may become dependent on the stimulative effect of the drugs. In our judgement at least one of the former patients called before us [patient 158] showed evidence of a possible dependence and several others had gone on to further long periods of taking slimming drugs. We find allegation (xxxi) proved.

iv. Allegation (xxxii) concerned Dr Berry's alleged failure to explain to patients the adverse side effects of phentermine and diethylpropion when he knew they had potential habit forming properties and thus failed to obtain informed consent from his patients. Dr Berry's case was that he always explained the side effects verbally at a first consultation. However the evidence he gave (see paragraphs 179-180 above) appeared to deal with a rather limited number of the potential side effects. He admitted he did not always give out a leaflet listing these side effects at that first attendance. We were unable to understand the rationale for this which we have recorded at paragraph 180 above and his answers in cross examination at paragraph 256. The practice he described was poor practice. If there is value in handing out a leaflet it is on the first occasion so that either then, or at leisure at home, the patient can see for herself what risks there were. A person prone to insomnia might therefore be disinclined to accept a drug with a known side-effect of causing insomnia. Of even more concern was that Dr Berry did not seem to have grasped some of the important side effects until he was questioned by Dr Lorimer, such as their potential effect when alcohol is also taken. Dr Berry said he merely mentioned alcohol as a

factor which might promote weight gain. We looked to see what assistance we might get from the contemporaneous records. On each card the receptionist filled out various headings to save Dr Berry having to write too much. One was "S/E", meaning side-effects. All that was required to indicate that explanations had been given was to place a tick against that entry. There were none. We were also shown numerous cards on which the word "leaflet" had been written in the left hand margin which is usually reserved for the date of the consultation. Such entries were frequent in April/ May 2006 and many others were inserted not at the first attendance but some later attendance. We were not satisfied from the appearance of these records that there was a system for recording the handing over of leaflets *on the date when that happened*, if it did happen. These entries often had the appearance of an addition at a later date. We did not feel we could place a lot of reliance on such entries. Against that we acknowledge that patients who gave evidence before us told us that they had been informed of the risk of side effects. Some were not sure what those might have been. Others gave a very limited list of potential side effects. Others were more comprehensive. In our view Dr Berry was not sufficiently concerned about potential risks from side-effects to have spent much or even (in some cases) any time in explaining the potential side effects to patients at an appropriate stage, that is to say before the patient was supplied with the drugs. We find allegation (xxxii) proved.

v. Allegation (xxxv) says that he persistently prescribed these two Schedule III drugs which he knew could create dependence. Mr Jenkins acknowledges on his client's behalf that the drugs could lead to dependence but submits Dr Berry is not to be criticised for that so long as he monitored patients carefully, as he did. We refer to the findings made above, in relation to the patients who had been on these drugs fro a long time. Dr Berry did not seem to have considered the issue of dependence when he supplied them. By way of example patient JN (N 17) who was called by Dr Berry, had a history of hypothyroidism, and had (she said) been on slimming tablets most of her adult life. She received a supply of slimming drugs fairly regularly from September 2004 to September 2005 (the last entry available at the end of a record card). We find allegation (xxxv) proved, although it may add very little to the thrust of the allegation at (xxxi). The two need to be considered together when considering the mischief to patients.

286. The second group of allegations were ones we characterised as "clinic management" although self-evidently they had a potential effect on patient welfare.

a. Allegation (xviii) was of requiring unqualified staff to supply Schedule III controlled drugs to patients contrary to the Misuse of Drugs Regulations 2001, on numerous occasions from 1995. The parties agree that this is a most serious allegation.

i. We refer to our findings about the witnesses generally in this context, and particularly the availability of evidence tending to confirm Donna Rule's evidence that there were occasions when she was left to operate the clinic on her own, including handing out slimming medication on a repeat basis taken from the previous supply recorded in the notes.

ii. Dr Berry conceded in evidence (contrary to the position he adopted in his initial letters to the PCT) that he would leave early on 5 or 6 occasions a year. It matters not whether this was an entire clinic or part of a clinic in the event that Dr Berry left early for some other commitment.

iii. We are satisfied that at the very least the patients whose names are listed at Schedules R1 and R2 and where the handwriting (including weight) is shown in those Schedules to be that of Jan Hutton or Donna Rule, were in fact seen, weighed, and supplied with slimming medication by Jan Hutton

or Donna Rule (as the case may be) at times when Dr Berry was absent and they were operating the clinic on their own.

iv. We do not believe that these were the only occasions because we have concluded that Dr Berry has tampered with many of the record cards, including by writing in a figure for blood pressure in a space which was otherwise left blank by the receptionist, so as to be able to suggest to us that he must therefore have been present on all those occasions when he has written in a blood pressure figure. We accept the evidence of Jan Hutton and Donna Rule that they would never have recorded the patient's weight if Dr Berry was present. Apart from anything else, the weighing scales were in his room and the receptionist sat in an outer area when he was present. There was only one set of scales used for the slimming clinic. Therefore each and every entry of weight by the receptionist is also likely to have been an occasion when, unsupervised, she supplied Schedule III drugs. It is not possible to say with certainty on how many occasions this occurred, partly because the records which Dr Berry has (in our view) either withheld or altered, make the paper record incomplete or unreliable.

v. Dr Berry's attempt to suggest that he would know a fortnight or so beforehand which patients would not be able to attend the clinic and therefore would pre-authorise drugs to be collected by the patient from the receptionist at a different time, was simply not credible. This was a walk-in clinic and although some made appointments, the evidence to us was that many more did not. He could not have known who was coming and who was not. Moreover he was unable to offer any credible explanation as to how he would pre-authorise the receptionist to do this in practice. His case seemed to be that he would simply tell her the patient's name and expect her to remember that name and (presumably) to check for herself from the records what the regular dose of slimming drugs was or else to remember what Dr Berry had told her it was. At another point in his evidence, Dr Berry seemed to suggest that he might sometimes have written the information on a scrap of paper for the receptionist, but this was equally unlikely and in our view merely offered to help bolster an explanation which was not being well received.

vi. We do not accept Dr Berry's evidence that if he had to leave early he made clear to the receptionist that she should telephone him if another (walk-in) patient should attend, or if there was any other cause to seek guidance, as he could be back at the surgery in a few minutes. There is no evidence that there was ever an occasion when the receptionist did in fact telephone him, and many occasions when she was faced with patients who had attended in Dr Berry's absence. There is no good reason why the receptionist should take it on herself to weigh the patient and hand out drugs if the true position was that Dr Berry had told her to phone him in that situation.

vii. We are therefore satisfied that Dr Berry did require his receptionist, who had no appropriate training or qualification, to supply Schedule III drugs to patients, and we are satisfied that this is contrary to the control regime in the Misuse of Drugs Regulations 2001.

viii. We reject Mr Jenkins' submission that the use of the word "required" implies coercion. It was in the broadest sense simply part of the job which the receptionist found herself obliged to do. We also reject his submission that regulation 7(3) permits the administration of a Schedule III drug by any person in accordance with the directions of a doctor. "Administer" must bear its normal meaning of applying or introducing the drug to the person of the patient. It is not apt to describe this factual situation.

ix. We find allegation (xviii) proved.

b. It is alleged that Dr Berry charged his NHS patients for medical examinations (xiii) or medication (xiv). The first of these charges relates (we are told) to Dr Berry's practice

of charging £10 to each patient who registered with his slimming clinic, even those who were already on his NHS list. This is factually correct, although it is not strictly correct to say (as does the allegation) that he was charging for a medical examination. He was charging for access to medical treatment, namely his slimming clinic. We have been shown documents indicating that Dr Berry's NHS practice does hold itself out as offering slimming clinic advice within the NHS framework. It is not clear whether this was ever actually available during the era of Dr Berry's private slimming clinic. We are satisfied that Dr Berry did charge his NHS patients for access to medical treatment which was, or ought properly to have been available to them as NHS patients, and we find allegation (xiii) proved in substance. We do of course bear in mind that Dr Berry has refunded these charges where he was able to trace the former NHS patient. It is also common ground that Dr Berry charged for each successive week's worth of medication. His case is that he did not know he was prevented from doing so. We have not been referred to specific regulations preventing Dr Berry from charging for supplying this medication. However the NHS scheme is free to registered eligible patients save for express exceptions such as prescription charges or services which are not covered by the NHS. We have heard uncontradicted evidence that the drugs used by Dr Berry in his slimming clinic were available to be prescribed on the NHS. He says that he did not think this was the case and this misapprehension was shared by many other people at the time. It is in our view contrary to good medical practice in any event. We are satisfied that allegation (xiv) is proved but we accept that Dr Berry is likely to have had a genuine belief that these two drugs were not available on the NHS. Whether that played any part in his selecting the drugs is hard to know. But it is all part of a very cavalier attitude to what he could properly do and what he could not. He simply treated his own NHS patients and private patients alike, despite the availability on the NHS of advice on obesity/ overweight problems and of slimming medication in an appropriate case.

c. Allegations (xxxiii), (xxxiv), (xxxvi) and (xxxvii) relate to the recording and storage of drugs and of preserving records.
    i. Dr Berry admits the factual elements of (xxxiii) namely failing to write the full name of the drug when prescribing it, or to write in words and figures the prescribed dosage, and on some occasions to write the patient's address, but Mr Jenkins submits that these requirements relate to the creation of a prescription and do no govern what Dr Berry should write on a record card, so that the allegation is misconceived. We agree that the words of this allegation appear to be taken from Regulation 15 of the Misuse of Drugs Regulations 2001, which relates to the form of a prescription. The allegation as presented is not therefore proved. This does not enable us to say that we are not deeply concerned about the want of adequate labelling on the bottles containing the drugs which were supplied to patients, which clearly *was* inadequate and in breach of Regulation 18 of the same regulations. Ms Tomkins also gave evidence about this labelling which was not challenged.
    ii. (xxxiv) alleges that Dr Berry failed to keep diethylpropion in a locked receptacle to prevent unauthorised access. There is clear evidence, which we accept, that it was kept in a desk drawer within the surgery, and that on many occasions this drawer was not locked. Even if it was locked the evidence which we accept is that several of his employees (including Jan Hutton and Donna Rule) knew where the key was kept (insecurely) and would take it to open or lock the drawer when they needed or remembered to do so. We accept the evidence of Donna Rule that she got drugs from the drawer and they were kept in little brown pill pots, and she distinguished the pills by their colour. She did not think they were labelled. She supplied them to the patient from the supply in the drawer, according to what had previously been supplied. We find that allegation (xxxiv) is

proved. On the wider point of safe and secure storage, Dr Berry told us that he kept his main store of medication at home in the garage and for that purpose installed a lockable safe which was bolted to the wall. We do not accept his safe (if he then had one) was bolted to the wall. The photograph he produced did not prove that and if anything showed it was free-resting on a box.

iii. By (xxxvi) it is alleged that Dr Berry failed to provide evidence that he had retained invoices for the supply of Schedule III controlled drugs as required by law and failing to retain such invoices. The law in question is Regulation 24 (2) of the Misuse of Drugs Regulations 2001. Dr Berry produced only two invoices, and he had obliterated much of the relevant and potentially useful information on each of the copy documents produced, so that it was not possible to see what quantities he had received. We are bound to say we are concerned as to what possible proper motive Dr Berry might have for so doing. There were more consignments of drugs received than are represented by these two redacted copies. We find this allegation proved. His method of operating did not permit any check to be made of how many pills had been properly supplied to patients and how many should remain in his drug supply. For all he or anyone else knew, anyone with access to his room might have taken amounts of Schedule III drugs from time to time.

iv. (xxxvii) alleged that Dr Berry had destroyed medical records of his patients without regard to or complying with legislation governing the preservation and destruction of medical records and has destroyed patient records when he was not permitted to do so. Dr Berry admitted “culling” the record cards of patients of his slimming clinic from time to time. His practice in this respect lacked any logical or rational justification, and was inconsistent even applying his own criteria. We know of no system in a GP setting which destroys patient records outright in this fashion, as opposed to transferring them to some “dormant” storage box or drawer. The justification was that Dr Berry was making room in the box so that the cards did not become too crowded, lest there might be misfiling. This is inconsistent with the presence of a number of record cards, to which we have referred, of patients who had been once or only a few times, and then not for many months before the clinic finally closed in May 2006. If Dr Berry’s explanation were correct, we would expect such cards to have been culled. They were not. We also take into account that after Dr Berry produced his typed list of all the patients in purported compliance with the Order of Mr Justice Jack, a diary for the slimming clinic was found at the surgery premises. It relates to a limited period from late 2004 to the end of 2005. Even by reference to this period it has been possible for the PCT to identify a number of patients, even from late 2005, who appear in the diary as appointments, but have no record card at all. Dr Berry could not say when this last cull took place. We found this evidence extraordinary and unbelievable. Mr Booth submits that even if true as an explanation, such destruction poses real risks for patient care in the future. Dr Berry’s account also proceeds on the assumption that there was only ever one box of record cards. We do not accept this. We find that when Jan Hutton stopped being the receptionist there were two boxes of cards. The evidence of Christine Ford was that when Dr Berry got her to type up a list of patients in May 2006 he had two boxes of cards with him. The evidence of Donna Rule that there were two boxes of cards during the time she was the slimming clinic receptionist is corroborated to that extent. We also consider that the evidence given by Dr Berry as to how many Lloyd George cards can be stacked in a box of the dimensions we have been shown is unconvincing. We are satisfied that there were two boxes of cards at the date of the Order of Mr Justice Jack in May 2006. In our view the

improbable explanation given by Dr Berry of his practice of intermittent culling of the records was to mask the real reason for destroying record cards, namely to remove any evidence of treating patients who he did not consider reliable (as we find he explained to Donna Rule) or might demonstrate poor or dangerous practice in his supplying of drugs, or management of patients. We find allegation (xxxvii) proved.

v. It is also alleged that Dr Berry required Christine Ford to imitate his signature (xliii) and to look out for any prescription that was "odd" (xliv). We accept the evidence of Ms Ford, a palpably truthful witness, and therefore find both these allegations proved. As she was imitating Dr Berry's signature under his direct supervision, the mischief would appear to be modest, but it is a further illustration of Dr Berry's irresponsible and unprofessional attitude and streak of arrogance occasionally emerging, when he said to her "they are too stupid to notice".

vi. Allegation (xlvi) is that Dr Berry restricted patients' access to him by failing to attend the surgery on alternate Wednesdays. We had very little evidence about this. We do not find this allegation to be proved.

287. The third group of allegations concerns patient confidentiality and it amounts one allegation only, namely that clinical information of an intimate nature was disclosed to Mr and Mrs Shiakallis about 3 other names couples and two other NHS patients of Dr Berry, when there was not appropriate reason for doing so. We found Mr Shiakallis to be a truthful and forceful witness, who was slightly emotional and had a hypersensitive approach to confidentiality. As Mr Booth submits, he could not have been expected to know about the matters he recounted (about difficulties in conceiving experienced by other neighbouring couples) unless these had been communicated to him by Dr Berry. We accept that they had been reasonably close social acquaintances, in a rather one-sided arrangement where Dr Berry became involved socially and would turn up at their house unannounced, but did not invite them to his own. We accept he quite liked to show off to the Shiakallises. We accept he was quite lonely at that stage of his life. The evidence of Mrs Castiglione was corroborative of what Mr Shiakallis told us about the disclosure of confidential information. We find that Dr Berry did reveal to Mr Shiakallis confidential clinical information of a sensitive nature and allegation (xlii) is therefore proved.

288. The fourth and last group of allegations concerns Dr Berry's honesty, probity and character.

a. We find that allegation (xxvi) – falsification of patient records – is proved. We are wholly unable to accept that the repeated examples of identical (and reassuring) blood pressure readings on successive attendances are contemporaneously recorded. Dr Berry had the record cards at home at some time after he was served with the Order of Mr Justice Jack in May 2006 for no reason which we can identify. His explanation was that he sometimes took the record cards home to tidy them up or complete a note he had not had time to complete, or to prune them. We know that otherwise the cards were kept in his room. We do not understand why any of the possible reasons he has advanced would require him to take the cards home rather than do that work in his surgery room. We have also noted above the position and dating of the word "leaflet" written on many of the Lloyd George cards. We are satisfied that many of these if not all were written at a later date to reinforce the evidence he intended to give that he had handed out leaflets alerting patients to possible side effects. We also accept that Donna Rule was asked by him on the very afternoon of the PCT "raid" to go to his garage and help him sort out the patient records. We are influenced in making this finding by our view that Dr Berry has consistently tried to pull the wool over the eyes of the PCT and subsequently of this Panel.

b. For the reasons set out above at paragraph 286 (c) (iv), we also find proved that Dr Berry destroyed medical records of his patients without regard to or compliance with legislation governing the preservation and destruction of medical records and has destroyed them when not permitted to do so: allegation (xxxvii).

c. It follows that we also find that Dr Berry falsely informed the PCT and PAG that he had supplied them all slimming clinic records that existed when he knew that to be untrue: allegation (xxxviii).
d. It is alleged (xxxix) that he asked Donna Rule to assist him by supplying false evidence to the PCT to the effect that Dr Berry was always present at the slimming clinic when in fact he was not. This is a reference to the letter written by Donna Rule on 10 October 2006 (D 24), in which that claim is made. This is in the same terms as a letter previously written to the PCT by Dr Berry (a claim which he now agrees overstates the case). It contradicts a statement which Donna Rule had already made to the PCT and within two days she contacted the PCT to retract the letter of 10 October. Why did this document which is at odds with every other statement or oral testimony of Donna Rule come into existence? In our judgement it came into existence broadly as she has described. It is no coincidence (as Dr Berry contended was the case) that the creation of the letter first arose as soon as Donna Rule's husband had disappeared to a different part of the house to take a telephone call. The phrasing of the letter is not what one would expect to see in a letter genuinely volunteered by a witness seeking to correct a misapprehension on the part of the PCT. It has some similarities with the letter written by Ms DL at a later date (which Dr Berry now admits was written at his instance, dealing with topics he suggested through an intermediary). The letter starts "to whom it may concern" as do other letters (eg from Mrs Lobb at D 27) written on behalf of Dr Berry. The content of the letter is inaccurate, as Dr Berry accepts: she did in fact give out drugs in his absence, from time to time. The assertion that she was trained and supervised can refer, at best, only to meeting and greeting and administrative support skills. The style is very far from the expression we associate with Donna Rule. It is very close to the expression we associate with Dr Berry. Donna Rule's account of Dr Berry's visit to her house is consistent with what we know of his contacts with other witnesses, such as Mrs DL. We did not find Dr Berry's explanation of an innocent visit to the home of an employee who had had a baby a convincing reason for his visit. It was almost 5 months since his suspension during which time he had had no approved contact with staff. He was aware that Donna Rule was (actually or potentially) a key witness against him, and he knew the terms of the concern which had been raised by the practice nurse Shelagh Byrne. It is those concerns which this letter appears to address. To accept Dr Berry's explanation of how Donna Rule volunteered this letter out of the blue would be to accept a bizarre explanation in preference to a credible explanation which is consistent with other evidence we have about Dr Berry. We accept that he prevailed upon her, at a time when she was rather fragile following the birth of her child, to write the letter at D 24 to assist his own position. We therefore find allegation xxxix proved.
e. Having regard to our view of the credibility of the witnesses, we also accept Donna Rule's account that Dr Berry told her she was the one who would be in trouble as a result of the PCT investigation unless she supported him by giving false evidence. There is no reason which we can identify why she should make this up. We find allegation (xl) proved.
f. As to allegation (xli) we note that Dr Berry admits it was inappropriate to invite DL to go out with him while she was his NHS patient, and that he acknowledges he had caused her embarrassment. We do not accept he was in doubt as to whether it was wrong to take these steps at the time. He appears to have been at a stage of his life when he was desperately keen to find a partner and this may have blurred his judgement. We are not satisfied that his conduct amounted to harassment, and so we do not find allegation (xli) proved. However the troubling feature of this episode is the lengths he went to in order to exculpate himself, by arranging for the victim of his misjudgement to write a letter. We have found those means to be dishonest. He pretended at first that Mrs DL's letter was her initiative and its timing fortuitous. It had to be dragged out of him that he had engineered it through an intermediary and suggested, at least in part, what it might be helpful to say. It was not helpful to out

view of Dr Berry's credibility that we felt he was trying to pull the wool over our eyes in respect of how the letter came to be created.

g. We find that allegation (xlix) – using Lloyd George cards belonging to the NHS for his private clinic when he was no entitled to do so – to be proved as Dr Berry admits but we do not regard this as serious compared to some of the other matters. It does however indicate a rather cavalier disregard of the distinctions between NHS and private practice. The corollary of this is the allegation (l) that he claimed ownership of the Lloyd George cards. We consider this adds nothing to (xlix).
h. Lastly it is alleged (li) that Dr Berry failed to cooperate with the PAG investigation. Mr Booth concedes this may add little to allegation (xlviii), that he was deliberately untruthful in his dealings with the PCT and PAG. We agree with that but we also consider that (xlviii) is proved for the reasons given above and is a serious matter since it makes the necessary relationship of trust and confidence between doctor and PCT unworkable.

289. In light of our findings on the specific allegations we are satisfied that Dr Berry' s continued inclusion in the Performers' List would be prejudicial to the services which those included in the List perform. There are many instances of serious deficiencies, and want of clinical skills and management. Sadly there is no evidence of any degree of insight into the nature and extent of those deficiencies. Dr Berry indicates he would not wish to resume operation of a private slimming clinic, but we find that is motivated by his desire to find a route back into practice rather than any recognition of what he has done wrong, how he has placed his patients at risk and what he might do to remedy that. Worst of all is the distasteful finding we have felt obliged to make that Dr Berry has been dishonest in a number of important respects in his dealings with the PCT, the PAG and with us. He has sought to manipulate the evidence, falsified or destroyed clinical records and sought to get witnesses to give untrue evidence favourable to himself. Extraordinarily in some cases (such as the allegation of harassment against Mrs DL) he did not need to do it, as our findings turn out, but he seems unable to resist the temptation to improve the state of the evidence.

290. In these circumstances we are driven to find that Dr Berry is unsuitable for inclusion in the Performers List. We do not see how the PCT could have any trust or confidence in their dealings with him in future. If a professional man is capable of dishonesty where his own interests are affected, it gives little confidence that the interests of the patient will always be given priority. It is a difficult judgement to reach but one which in our view is unavoidable.

291. For the reasons given above Dr Berry's appeal is dismissed and we direct that he be removed from the Performers' List.

292. The PCT also invites us to impose a National Disqualification on Dr Berry. We invite the parties to make submissions in writing within 28 days of receiving this decision. They are of course entitled to an oral hearing should they wish. Any application for an oral hearing should be made at the same time.

293. In accordance with Rule 42 () of the Family Health Service Appeal Authority (Procedure) Rules 2001 the Appellant is hereby notified that he may have the right to appeal against this decision under Section 11 of the Tribunals and Inquiries Act 1992. Any appeal shall be made by lodging a notice of appeal in the Royal Courts of Justice, The Strand, London WC2A 2LL within 28 days from the receipt of this decision.

Duncan Pratt

DUNCAN PRATT

Chair of the Panel appointed to determine this appeal

1 September 2008