First-tier Tribunal Primary Health Lists

The Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care) Rules 2008

IN THE MATTER OF AN APPEAL UNDER THE NHS (PERFORMERS LISTS) (ENGLAND) REGULATIONS 2013

2024-01231.PHL

Heard on 31st March, 1st and 2nd April 2025 in Birmingham Civil Justice Centre
Panel Deliberation: 11 April 2025

BEFORE
Judge Christopher Limb
Professional Member D Cochran
Specialist Member M Cann

BETWEEN:-

Dr Sacha Simon

Appellant

v

NHS England

Respondent

DECISION

Attendance:

Dr Sacha Simon (Dr Benjamin and Mrs Simon attending as supporters) and Mrs M Edwards (executive officer Warwickshire LMC, by video on 2.4.25)
Mr Peter Anderson (counsel for NHS England "NHSE"), Dr Murphy (senior clinical adviser and associate medical director at NHSE Midlands) and Dr M Anwar (medical director NHSE Midlands and since April 2021 Responsible Officer for Dr Simon)

Preliminary

1 This tribunal can make any decision which the Respondent could have made (Regulation 17(4)). This is a rehearing.

2 The issues in the appeal concern the imposition of conditions ("the conditions") upon Dr Simon's inclusion in the performers list ("PL"). The conditions are found in the decision letter dated 5.8.24 (A10-13).

3 Dr Simon sought unconditional inclusion upon the PL, although accepting that supervision should continue (in effect upon a voluntary basis).

4 NHSE sought continuation of the conditions.

5 Dr Simon made an application to submit additional evidence. There was no objection by NHSE and we gave permission. The short bundle of 24.3.25 related to cancellation of services at Dr Simon's practice (letter 19.3.25) and related documents together with a letter of 14.11.23 requesting review of suspension payments. The short bundle of 27.3.25 includes interim reports from both Dr Kanwar and Dr Wiratunga, respectively clinical and educational supervisors appointed pursuant to the conditions.

6 We were provided with both a bundle and a supplemental bundle of written evidence and were also assisted by both written opening and closing submissions from both parties. The written evidence is substantial and must be read in conjunction with this decision. The oral evidence was substantial and this decision contains only a summary of parts of it.

Background

7 Dr Simon practiced from Whitestone Surgery in Nuneaton and was a sole practitioner. He joined the PL in January 1996.

8 In August 2020 NHSE received allegations of two patients receiving inappropriate invitation to read the bible and pray rather than clinical treatment for mental health issues: this was considered by triage. In September 2020 more widespread allegations of inappropriate treatment and care were received from an anonymous source (C27/28). A complaint relating to 2017 was considered by the MPTS and after delays due to a combination of Dr Simon's ill health and covid, it was decided that his fitness to practice was not impaired and the GMC closed the case. The allegations made in September 2020 were initially considered by triage and then by a medical director of NHSE and Dr Simon was suspended on 17 September 2020 under regulation 16 ("for the protection of patients or members of the public or otherwise in the public interest"). The suspension was reviewed by the PLDP and upheld the following day. It was noted that the allegations included concerns relating to deaths of 3 patients and an investigation in the form of an independent records review of those 3 patients and 27 other records chosen at random was to be undertaken. Following notification of suspension to (inter alia) the GMC, the GMC opened a case and the IOT

issued an interim order of suspension. There was then a mandatory suspension by NHSE (regulation 12).

9 The GMC closed the case on 2 May 2024 and the mandatory suspension automatically stopped. At the same time the CQC proceeded to cancel the registration of Dr Simon's practice. The conditions with which this is appeal is concerned were subsequently imposed.

10 The evidence relied upon and in particular the evidence of independent review, expert witnesses, the GMC case examiner report, and the clinical and educational supervisors interim reports are further referred to later in this decision.

Issues

11 Both parties confirmed on the final day of hearing that their positions remained the same and that the issue is whether the current conditions should be maintained or whether there should be no conditions (neither party contended for different conditions).

Legal Principles

12 The Regulations are included in full within section E of the bundle and we do not set out full quotations within this decision.

13 Regulation 10 provides that conditions for the purpose of preventing prejudice to the efficiency of services may be imposed.

14 In his skeleton argument Mr Anderson refers to the cases of *Dr H v NHS England [2023] UKUT 18, East Lancs PCT v Pawar [2009] EWHC 3762 and the FtT decision in Dr Rahman v NHSE [2024] 01075.PHL*. We accept that he correctly summarises relevant parts. In particular, "efficiency" refers to competence and quality of performance and can include concerns regarding probity, credibility and insight; that decisions of the GMC as to fitness to practice do not determine matters relating to the PL and prejudice to efficiency is wider than fitness to practice; that a decision of the GMC to revoke conditions did not necessarily equate to exoneration; and that the tribunal does not have jurisdiction to order payment by NHSE for either remediation or an equivalent of a Return to Practice pathway.

15 In general terms we must act reasonably, fairly and proportionately.

Evidence

16 Prior to summarising central parts of the evidence, we note the Scott Schedule. The majority of the items are "accepted" and no issue arises. Dr Simon has added comments following "accepted" on some items. Item 3 is accepted by Dr Simon but he does not accept that the complaints were well-founded. The expert evidence which does or does

not support those complaints as well-founded is dealt with in later items and elsewhere in the evidence. Item 7 (relating to Dr Ghattaora's ("DrG") review findings) was confirmed as accepted by Dr Simon during the hearing. Item 8 (relating to Dr Simon's response to DrG's findings) is accepted and his further comments relate to the steps he has taken to improve his practice: the adequacy of such steps is part and parcel of our consideration as to whether conditions are or are not appropriate. Item 13 is accepted and Dr Simon's further comments relate either to the conditions which are or are not appropriate and to whether NHSE deliberately delayed the start of the conditions. In the course of the hearing Dr Simon accepted that there was no deliberate delay. Item 14 is accepted and the further comment similarly refers to the (abandoned) issue of delay. The further comments following acceptance of item 14 similarly relate to the (abandoned) issue of delay. The further comments following acceptance of items 16 and 17 also relate to an aspect of delay (abandoned). The further comments following acceptance of items 19, 23 and 24 relate to the argument as to whether conditions are appropriate and that is the essence of the decision being made in this appeal and dealt with later in this decision. Item 25 relates to the CQC cancellation of the registration of the practice which prior to this hearing had been upheld by the Care Standards Tribunal. The only remaining issue (item 12) in the Scott Schedule is whether the GMC decision is an exoneration of Dr Simon. We therefore give our judgment on that issue later in this decision.

17 The report of DrG in November 2020 (C34 onwards) was based upon a record review of the 3 patients who had died and of 27 other patients chosen at random. The terms of reference state that the purpose of the investigation is to determine whether Dr Simon's professional performance compromises patient safety. In relation to 2 of the patients who died DrG was critical of decisions as to medication prescribed and in all 3 cases was critical of the quality of record-keeping and lack of essential information to justify management. In relation to the records of the other 27 patients DrG considered 20% to be unacceptable, 66% to be of concern and 14% to be acceptable. Dr Simon's responses (C55-66 and 67-89) accepted almost all the criticisms.

18 The following reports available to NHSE and to us are only those that have been disclosed by the GMC. The report of Dr Harker ("DrH), appointed by the GMC, (D89 onwards) advised that 7 of the random 27 patients received care below but not seriously below the standard to be expected of a reasonably competent GP. The report available to us does not address the 3 patients who died but Dr Simon instructed Dr Middleton ("DrM") to advise in relation to those 3 patients and one other and we have a summary of his views in the GMC case examiner's report (D202-4) and also (D205) the outcome of a joint meeting between DrH and DrM. In part their views depended upon whether Dr Simon's statement as to matters not in the records was accepted, but they agreed that for patient A conduct was below but not seriously below standard if his statement was accepted, that for patient B they disagreed but DrH

maintained the view that care was seriously below standard, that for patient C they disagreed but DrH maintained the view that care was seriously below standard, and that for patient D they disagreed but DrH maintained the view that care was seriously below standard.

19 The GMC case examiner decision that the referral of Dr Simon to a hearing should be withdrawn notes the differing expert views and explains his decision ((D206-211). In relation to 3 of the 4 patients he is of the opinion that if DrH's opinion is preferred to that of DrM there remained a realistic prospect that Dr Simon's care would be found to be serious, ie meet the GMC test. In relation to the test of whether fitness to practice "is currently impaired" he notes that in principle clinical concerns are generally remediable and that Dr Simon had been undertaking relevant CPD and had demonstrated reflection and that in those circumstances there was no realistic prospect of a medical practitioners tribunal finding of current impairment.

20 The most up-to-date independent expert evidence is that of Dr Wiratunga ("DrW") and Dr Kanwar ("DrK"), the educational and clinical supervisors appointed and approved pursuant to the conditions. Their reports are dated 26th and 27th March 2025, namely during the week prior to this appeal being heard.

21 DrW concludes and advises that Dr Simon has engaged with his Personal Development Plan tasks and demonstrated both reflection and tangible action in response to the areas of concern.

22 DrK uses the clinical supervision feedback form which measures each area as above expectation (1), competent (2), needs further development (3) or below expectation (4). We were informed that 27 clinical sessions had taken place. History and Examination are scored 3 but have the comment that "Notes are not inaccurate but I have advised that needs to have more clinic detail recorded and relevant negatives". Clinical management, Investigations, and Emergency Care are scored 3. Problem Solving Skills are scored 2 with the comment "I feels needs further experience managing long-term conditions.. due to absence there is a knowledge gap with certain protocols.. I do advise that when following up patients who have seen another clinician to have a bit more deeper analysis of records as to be better prepared to see them". Learning and Development is scored 3 with the comment "Takes on board feedback". Communication and Teamwork is scored 3 with a positive comment on feedback. Team working skills is not scored as Dr Simon has not yet been asked to work as a team leader. Professional Integrity is scored 3. Primary Care Administration and IM&T are scored 3 with the comment "records are brief and have advised ideally to have more negatives". Understanding of NHS systems and community orientation is scored 2. Ability to deal with pressure and Organisation and planning are scored 3. There is competence in safeguarding children and young people and attendance/timekeeping were satisfactory. By the nature of an interim report there is no current

recommendation for PL inclusion. The report refers to one complaint on 24.3.25 with a satisfactory response.

23 We have read the 3 written statements of Dr Murphy. In large part he gives the detailed history of this appeal. He also confirms that he has had an advisory role and confirms that he is of the view that absence of conditions would allow Dr Simon to return to unrestricted practice without recent clinical experience and with unresolved clinical concerns; that initial concerns were corroborated by independent record review; and that the conditions are reasonable and proportionate to keep patients safe and are workable. His 3rd statement largely refers to further evidence including similar concerns which followed the CQC intervention.

24 In his oral evidence he confirmed his opinion that Dr H did not discredit DrG, that there was no deliberate (or other) delay by NHSE, and that the conditions were not open-ended and that he/NHSE were open to earlier review if Dr K suggested it. He considered that the supervisors' reports showed positive progress but still areas needing remediation. He was questioned at length by Dr Simon. He confirmed that his role did not include clinical excellence but concerned patient safety and that a major concern was the circumstances of the 3 patients who died. He did not think there were extenuating circumstances for failings in the Docman system. He considered that the issues relating to prescribing concerns did put patients at risk although it could not be proved that deaths were caused them. He confirmed that NHSE was a separate body and mutually independent of other regulatory/supervisory bodies such as the NMC, ICB and GMC. Although Dr Simon suggested there was a conflict of interest (albeit without clear definition) he denied any. In response to Dr Simon's suggestion that he had been exonerated by the GMC, he referred to Dr Simon repeatedly having made such suggestion and to having "done nothing wrong" and that he considered that Dr Simon lacked insight and has accepted that there are concerns that need to be addressed but also asserted that he had done nothing wrong. He considers that the report of Dr K confirms that there are still areas requiring remediation. In response to Dr Simon's reference to a review of his entire records, Dr Murphy said that this was by the ICB and he had had no knowledge of it being initiated. Although the judge suggested to Dr Simon at the beginning of the afternoon session that he should cover the concerns/areas which are said by NHSE to not be yet remediated if he disagrees with their position, he did not put any such questions. During re-examination, Dr Murphy referred to undertakings having been suggested but not accepted by Dr Simon and outlined the history in the autumn of 2024 leading to appointment of supervisors and involving no delay by NHSE.

25 Dr Anwar confirmed his statement and that he has been the Responsible Officer ("RO") for Dr Simon since April 2021 but has never been a decision maker (which was the PLDP). In his oral evidence he rejected any suggestion that there was evidence of Dr Murphy having shown

aggressive punitive actions against the only black GPs in the region: a look-back examination was conducted and found no such behaviour but rather his acting wholly in line with expected behaviour. In answer to Dr Simon's questions he said that clinical excellence was not part of the statutory role of the RO. He said that he was not aware of any deviation from the guide for responding to concerns about medical practice (D423-81) and was not directed to any specific example. He considered the conditions proportionate to ensure patient safety. He had no view as to the merits of the proposal (Dr Simon statement para 18 at D4) that suspension is not a neutral act and that the system should be overhauled.

26 Dr Simon confirmed his 3 statements. They and their numerous appendices are very lengthy and it is not possible to give a succinct summary. We have read and considered them all. His 1st statement includes reference to the financial impact of his lengthy suspension and the difficulty of finding supervisors; refers to seeking access to the Return to Practice scheme (for practitioners who have been out of practice after a career break); refers to "exoneration" by the GMC and to their finding the record review deficient; refers to "egregious" handling of his case by NHSE; refers to those who made the allegations being conflicted; and refers to his alleged status as a whistleblower. His 2nd statement includes reference to local disputes as to potential new critical primary care infrastructure and suggested connection with the anonymous allegations. His 3rd statement refers to the actions of the ICB and CQC leading to the CST decision; refers to "unusually aggressive" actions by NHSE led by Dr Murphy against black GPs; and makes very substantial references to what are said to be evidence of clinical excellence over many years, including as far back as 2012 in a letter to the Haiti prime minister outlining a strategy to assist following a natural disaster; and refers to "relitigation" of the allegations considered by the GMC.

27 Having referred to some of the matters in his statements, he identified what he said were the "core issues" : his extensive CPD over the last 4 years; exoneration by the GMC; his reflection upon issues raised; and the absence of evidence for the allegations in 2020. He was cross-examined by Mr Anderson. He was referred to his email on 28.5.24 to his MP (C113) and reference to "NHSE have maintained a posture of consistent threat, intimidation and unduly harsh disciplinary actions". He said he believed that was true at the time but not now and withdrew it. He said that he still maintained that NHSE had been "deliberately slow" in resolving his return to work (D209 para 2) but after detailed reference to documents from August 2024 onwards he withdrew it. He accepted that he was on poor terms with other local practices (which contributed to difficulty in finding supervisors) and accepted that NHSE were not responsible for any delay in his finding a supervisor and then approving DrK and DrW. Having been referred to his statement (D12 para 75) that he was denied access to the Return to Practice scheme by NHSE, he accepted that he had not proceeded with an application. Having been

taken in detail through the criticisms of DrG, Dr Simon accepted them but questioned the motives for the investigation. He later said "I accept the concerns in the record review. I don't accept they are unremedied" and that the concerns have been addressed. He accepted that DrH did not discredit DrG, and in particular accepted the various concerns about record-keeping. He was referred to the report of DrK. In addition to areas which were either not scored as competent or scored competent with additional comments of concern, he was referred to the reference to a complaint and his failure to notify the NHSE (part of condition 6). He said that was "good to know", as though unaware of the condition. He said that he was happy to continue to work with DrK but without formal conditions and being able to earn a living. He was referred to various of the exhibits said to show clinical excellence. When referred to the email to Dr Murphy at C119 which is copied to numerous people including not only health organisations and individuals but also media, Mr Anderson suggested it was eccentric and Dr Simon accepted that he had talked to the Daily Telegraph but didn't explain the suggested relevance to this appeal. He was referred to the letters at D133 and D135 (the first allegations received by NHSE) and initially said that he was not sure that they were his patients and then accepted that they were and had also been referred to in the GMC proceedings. He accepted that what he had referred to as whistleblowing took place long after NHSE had taken initial action.

28 We heard evidence from Mrs Edwards by video, having read her written statement. Having confirmed her view that suspensions are not neutral acts and that there are practical difficulties in finding clinical supervisors and having acknowledged that she does not have status to comment on clinical performance or ability, she agreed in response to Mr Anderson's questions that her specific concerns have been allayed since DrK was appointed and her concerns about funding are not specific and not for this case to decide.

29 We have read the statement of Ms Halford-Hall and her concerns about the treatment of whistleblowers. Paragraph 16 of Dr Simon's closing submissions refers to her evidence but does not explain its relevance in the context of his acceptance that the timetable was that any whistleblowing took place long after the NHSE had taken action.

30 The conditions subject of this appeal are set out in the decision letter (A10-14) and should be read in full. The conditions of most relevance to the disputes in this appeal are the following. The condition for clinical supervision requires approval by the RO, to be in place for a minimum of 50 patient-facing sessions (albeit Dr Murphy indicated he would review if DrK suggested it at an earlier stage), reports after 25 and 50 sessions, review by the RO, and continued supervision until review by the PLDP. There are requirements for educational supervision (DrW). There are requirements for notification of various matters including any complaints.

*

Decision and Reasons

31 The only remaining dispute upon the Scott schedule relates to whether or not the GMC "exonerated" Dr Simon. We preface our conclusions on that topic by saying that this tribunal is not bound by any finding of the GMC. A finding of the GMC or other regulator is relevant and we give it respect but it does not bind us. Moreover, fitness to practice is not the same issue as efficiency of services which is wider. Upon the evidence the GMC did not clear Dr Simon of the allegations made and did not exonerate him. We refer to paragraph 19 above. Apart from indicating that some potential criticisms depended upon whether one or the other of the experts was accepted (which he did not purport to decide), the case examiner clearly concluded that remediation was required. Remediation is the purpose of the conditions in this case.

32 At various points in the evidence Dr Simon has made allegations of improper or inappropriate actions and motives by NHSE and/or Dr Murphy personally. We refer to the evidence summarised in paragraph 27 above. Dr Simon expressly withdrew most such suggestions. It was not clear to us whether he withdrew suggestions of racial bias, but he gave no evidence (rather than simply asserting the allegation) to support it. Moreover, we were impressed that NHSE undertook an investigation when the allegation of aggressive punitive actions against black GPs was made and we heard no evidence to displace their conclusion that there was no such action.

33 We consider that it is important to note that NHSE do not allege that Dr Simon is to be criticised for all aspects of his practice but rather in the specific areas identified in the various record reviews and in the recent clinical supervisor report. The authors of those reviews and reports are not NHSE itself but experts commissioned by them or by GMC. If there is well-founded concern as to aspects of safe clinical practice (the essence of efficiency of services in the current context) it is not at all clear why any such suggested bias/motives/behaviour would (even if proved) render the identified concerns nullified in the absence of evidence as to show that the reviews and reports were tainted and not reliable. There is no such evidence. The reviews and reports are not those of NHSE itself.

34 Dr Simon makes extensive references to what he contends is evidence of clinical excellence. That is not suggested to be evidence of clinical practice in the areas of criticism but in wider areas of work. It is difficult if not impossible to understand what is the suggested relevance to the issues in this appeal. By way of an extreme example, we find it is impossible to understand any relevance in the matters referred to in the letter to the prime minister of Haiti in 2012.

35 The matters referred to in the two previous paragraphs cause concern as to whether Dr Simon was either seeking to draw attention away from the areas of concern upon which NHSE relies or has not carefully

considered what those concerns are. The extent of his insight into the issues is important when considering whether remediation is still required and/or whether remediation is likely to be achieved. He continues to believe that the GMC exonerated him when it is plain from the case examiner's report that remediation was required and thought to be possible. Dr Simon himself told us that he accepted the concerns in the record review and that they remain unremedied whilst also suggesting he was exonerated. Apart from financial issues, he made no argument as to why necessary remediation should be on a voluntary basis.

36 When he was questioned as to his failure to report the complaint referred to in DrK's report, Dr Simon appeared to be unaware that he was obliged to do so. He seemed surprised without explaining whether or if he had carefully read the conditions. It was not even clear that he took the matter seriously: his response "good to know" was almost light-hearted. There was no hint of contrition. On a wider level Dr Simon did not show contrition. His practice has been subject to investigation by GMC and CQC as well as NHSE but he did not refer to or demonstrate reflection on failings nor contrition for failings. His approach in all investigations has included contesting suggestions of failings rather than reflection upon issues arising. We conclude that there is little if any insight into his own failings, even though he accepts there are issues requiring remediation.

37 We have concluded that remediation is required. Dr Simon accepts that. We reject the suggestion that remediation should be allowed to take place on a voluntary basis. It is the duty of NHSE to take action if it considers that there is a realistic risk to patient safety and therefore prejudice to efficiency of services. In our judgment the imposition of conditions is an appropriate and proportionate way to act. Our conclusions as to lack of insight and lack of contrition strengthen the conclusion that management of the conditions is required. We have some doubts as to whether remediation will be demonstrated with lack of insight but that will be subject to review according to the terms of the conditions.

38 Dr Simon made no suggestions of alternative wording of conditions if we decided that conditions should be imposed. The conditions are self-evidently practical and workable and have enabled the supervisors to carry out their functions. We consider that the current wording is appropriate reasonable and proportionate and will enable NHSE to undertake its proper regulatory and supervisory functions, and thereby to prevent prejudice to the efficiency of services.

Order

The appeal is refused and the current conditions shall remain in force.

Tribunal Judge Christopher Limb

First-tier Tribunal (Health, Education and Social Care

Date issued 29 April 2025