Care Standards

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

[2015] 2364.EA-SUS

MUJIB UL HAQ KHAN **Appellant**

and

CARE QUALITY COMMISSION

Respondent

Before: Mr Andrew Lindqvist
Dr Keith White
Mrs Janice Funnell

Heard on 25th March 2015

Dr Simon Fox of Counsel (instructed by Cubism Law) appeared for the appellant,
Mr Iain Macdonald of Counsel (instructed by Mills & Reeve LLP) appeared for the respondent.

DECISION

1. Dr Mujib Ul Haq Khan appeals against the decision of the Care Quality Commission (hereinafter ' CQC ') of 8th January 2015 to issue a notice under s.31 of the Health and Social Care Act 2008 suspending for four months his registration as a provider of treatment of disease, disorder or injury at his surgery at 78 Granville Road, Southfields, London SW18 5SG. The notice is dated 9th January 2015 and was served on Dr Khan that day.

Background

2. Dr Khan has practised as a GP for some 40 years, the last 33 of them at his Granville Road surgery. During that time four complaints had been made about him, all were quickly dismissed. He had no regulatory problems until the end of 2013, when the CQC required compliance actions. Having found no improvement despite the provision by Dr Khan of an action plan, the CQC issued a warning notice in July 2014. Not long after, that NHS England issued a remedial notice and some improvement resulted, but the CQC issued further warning notices in September 2014. On 17th November 2014 the Performance List Decisions Panel suspended Dr Khan for six months. Unable to provide medical services to his

patients, Dr Khan employed a number of locum doctors but visited his surgery on a daily basis to deal with administration.

3. On 6th January 2015 the CQC carried out a further inspection which identified deficiencies in the practice's records in a number of respects, and in availability of emergency medicine. The decision to suspend Dr Khan's registration as a service provider was consequently made on 8th January, and the notice was served the next day.

Preliminary matters

4. Judge Melanie Plimmer gave directions for a hearing on Thursday 26th February 2015, exchange of evidence by 16th February and provision of a bundle of documents by 19th February. Her order is dated 6th January 2015, which must be an error; it predates the decision under appeal and should probably read 6th February 2015.

5. On 23rd February, Judge Plimmer gave further directions, at the appellant's request, providing for a hearing on 25th March, a hearing bundle by 6th March, skeleton arguments by 18th March and notification of required witnesses by 25th February. That order recorded the parties' confirmation that all relevant evidence had been exchanged.

6. On 20th March, the appellant sought leave to introduce further evidence, and Judge Lindqvist directed that that application be dealt with at the start of the hearing.

7. On 23rd March, the appellant sought further discovery, of communications between the CQC and NHS England and, the respondent having declined to provide such discovery, the appellant sought a telephone case management conference on the afternoon of 24th March with the same object. Judge Lindqvist refused the application for a telephone case management conference because the disclosure did not relate to matters of primary relevance, the request was made at the last possible moment and it involved witnesses retrieving electronic documents which it was wholly unreasonable to ask them to do two or three working hours before the start of the hearing. It also appeared that the introduction of further evidence might result in an adjournment (either because the CQC would need time to consider and respond to it or because it would take the hearing into a second day) and the suspension under appeal was due to expire on 8th May.

The hearing

8. A reporter from the local press having identified herself, the Tribunal made an order under reg.18 of the Protection of Children and Vulnerable Adults and Care Standards Tribunal (Children's and Adults Barred List) (Transitional Provisions) Regulations 2008, prohibiting publication of the name of any of the appellant's patients. In the event no such name was mentioned during the hearing.

9. The appellant's application to introduce further evidence was not opposed by the respondent and, upon Counsel's assurance that its introduction would not add

significantly to the length of the hearing, the Tribunal allowed the application and pages H 1 -- 85 were added to the bundle as were some photographs of the appellant's surgery.

10. The Tribunal considered it essential to complete the hearing in one day, because adjournment part-heard would result in a decision so close to the expiry of the appellant's suspension as to render the appeal practically otiose. The Tribunal therefore proposed a timetable limiting cross-examination and was grateful for the co-operation of Counsel, who agreed to and adhered to the timetable. With one exception, examination in chief was restricted to confirmation of the witness's statement.

11. The witnesses who gave oral evidence for the respondent were Mrs Emma Dove, Mrs Rebecca Gale and Dr Stephen Richards. Dr Jayne Fryer, who had provided a witness statement was not required for cross-examination. For the appellant, Dr Khan himself and Dr Fernando gave oral evidence. Drs Luqmaan Malik and Noor Ahmad provided witness statements but were not required for cross-examination.

The evidence

12. In her witness statement Mrs Dove, a CQC inspector with 14 years experience, described the inspections carried out in 2014, what was seen and the consequences. She also dealt with the inspection of 6th January 2015 when it was found that,

i) the arrangements for recruiting locum doctors were not safe,
ii) systems to identify and deal with risk were lacking,
iii) fire precautions were inadequate,
iv) child protection and adult safeguarding procedures were deficient,
v) emergency medicine was not available, and
vi) systems for the recording and dissemination of information were lacking.

13. Cross examined, Mrs Dove agreed that her concerns in 2015 were different from those which arose in the previous year's inspections, but, she said, they were of the same type and were breaches of the same regulations. She agreed that the CQC could have imposed conditions on the appellant's practice. With regard to the checks on locum doctors, she said that Dr Khan told the inspectors that he had carried out some, but not all, of the required checks, but he was not able to provide documents relating to the checks he said he had carried out.

14. In relation to emergency medicine, Mrs Dove's concern was that Dr Fernando, the locum doctor at the practice on 6th January, did not know whether emergency medicine (in particular adrenalin) was available or, if so, where it was to be found. She was also concerned about the lack of fire drills and a lack of staff training both in respect of fire and child protection. She said that she had made allowances for the size of Dr Khan's practice.

15. Mrs Gale, an Inspection Manager, who had worked for the CQC since April 2009, also described the 2014 inspections and the actions required of Dr Khan.

She was not at the inspection of the surgery on 6th January but was at the meeting on 8th January, when it was decided to suspend Dr Khan's registration.

16. Cross examined, Mrs Gale agreed that she had relied on information from colleagues, and that the concerns in 2015 were different from those of 2014, though, under the same regulations. For example, although there were concerns about emergency medication in both years, the specific concerns were different. She agreed that there was a scale of measures which the CQC could apply, from compliance action to cancellation of registration and accepted that the CQC had proceeded from warning notice to suspension without taking the intermediate step of imposing conditions. The defective documentation alone, she said, would not justify suspension. The only fire risk issue was the use of an extension lead -- not in itself a significant concern, but it was a concern that there was an inaccurate record, and that emergency medication was not available. She said that while it was open to the CQC to impose conditions, it was felt that management deficiencies were such that suspension was the appropriate and proportionate response.

17. Dr Stephen Richards was the only witness to give oral evidence in chief. He did so to deal with an issue arising out of the further evidence of the appellant admitted at the start of the hearing. That evidence included printouts of computer patient records and Dr Richards described the system under which each doctor has a card and a password which he/she can use to log on to the countrywide system. He produced his own card to show to the Tribunal.

18. On 17th November 2014, Dr Khan had attended a hearing before the Performance List Decision Panel, yet, according to the medical records, he had seen a patient with a shoulder problem on that day. It appeared that Dr Khan had allowed a locum doctor to use his card to log on to the system.

19. In his witness statement, Dr Richards described concerns arising out of the 2014 inspections. He did not attend the inspection of 6th January 2015 but was at the meeting two days later. He recounted the concern of Dr Chaudery (who was at the inspection) that immunisation had been given with no adrenalin accessible.

20. In cross-examination Dr Richards said that misuse of the card was primarily a matter for NHS England, but might also involve the CQC. He did not accept that any circumstances justified one doctor’s use of another's card, but if it did happen there should be a clear record of the matter so that the identity of the doctor who in fact treated the patient appeared in the notes. Dr Richards was aware that the GMC had imposed a condition that Dr Khan did not work alone but with at least three other doctors. He emphasised the importance of having adrenalin available when vaccinations were given because of the risk of anaphylactic reaction. Oxygen too should be available. Although anaphylactic reaction was very rare, it could be very serious -- even fatal -- and immediate availability of emergency medicine was of high importance (' you need to be able to put your hands on it '). Had the CQC been satisfied that adrenalin was available, suspension might not have been the outcome.

21. In answer to a question from the Tribunal, Dr Richards said that the five yearly revalidation achieved by Dr Khan at the end of May 2004 was not solely a clinical matter, but also involved practice management. Part of it was done online, but there was always a face-to-face meeting with an appraiser, lasting about two to four hours.

22. Dr Jayne Fryer, a Medical Director for NHS England, who did not give oral evidence, dealt in her witness statement with the concerns of NHS England about Dr Khan's practice in 2014. She was aware of, but had no part in, the inspection of 6th January 2015 and Dr Khan's consequent suspension.

23. The appellant, Dr Khan, made three witness statements. In the first, made on 17th January 2015 he dealt with his experience as a doctor and the events of 2014, including his six month suspension from the Performance List by the Performance List Decisions Panel in November. He said that when the CQC inspectors arrived on 6th January he was expecting them to check his compliance with their previous demands. As to the concerns raised on that occasion, Dr Khan said that the locum doctors were fully qualified and trained, most were employed through reputable agencies, one through a personal connection. They knew how to deal with vulnerable patients, and in an emergency could consult the Practice Manager or call Dr Khan on his mobile phone. He agreed that there was no induction pack for the locum doctors, he suggested that a formal induction pack was unnecessary and that an informal introduction tour of the small surgery premises was sufficient. Again, the Practice Manager could help if the locum doctor could not find what he/she needed, and Dr Khan himself was available on his mobile phone.

24. The medicine bag, (which proved to be part of the only major factual controversy) was, said Dr Khan, available at all times in the surgery. It had two combination locks, one of which was jammed. He was not asked to open the bag on 6th January but easily opened the jammed lock with a handy screwdriver after the inspection. In the event of a fire or an emergency of any kind, Dr Khan said the Practice Manager would know what to do. She and the receptionist had worked at the surgery for about six years. Dr Khan felt that the CQC (and NHS England) had been heavy-handed in their treatment of him. An article about him in the Wandsworth Guardian was derogatory and the closure of the surgery had had a devastating effect on him.

25. Dr Khan's second witness statement, of 20th March 2015, had as exhibits letters from NHS England dated 2nd December 2014 and 18th March 2015, and his solicitor's reply of 19th March 2015 to the latter. That correspondence concerned a request from NHS England for information about how Dr Khan was running his practice (before 6th January 2015), and his allegedly inadequate response to that request.

26. Dr Khan's third witness statement concerned the provision of emergency medicines. Records showed that the two patients who received injections on 6th January began their respective consultations with the locum doctor, Dr Fernando, at 10.38 and 11.09 respectively. (Dr Khan said elsewhere that he had arrived at 10.15.) The first had an injection of Prostep 3 (for cancer), the second a ' flu jab '.

In the latter case, only, there was a minimal risk of anaphylactic reaction, the patient having previously and uneventfully had a similar injection.

27. In cross-examination Dr Khan said that he did not have the records relating to the locum doctors available for the inspectors because he did not know that that was one of the purposes of the CQC visit. He had made checks with the GMC and the MDU but he was unable to say which of the locum doctors he had recruited through personal contact rather than through an agency, (though in his solicitor's letter of 19th March 2015 it was said that Drs Ahmad, Memon and Zaffar were employed through personal connection). In that same letter, Dr Khan accepted that he had no CVs for Drs Memon and Zaffar, and he explained in oral evidence that that was not a concern because he knew them well. He accepted that his checks were not thorough but made the point that all the locum doctors were suitably qualified and registered and were on the Performers List and added that he was not aware that further checks were required and would have carried them out had he known.

28. That observation led on to a complaint (which to a degree will evoke sympathy from many) that the volume of regulation is such that it is no longer possible to digest and apply it all and to do the clinical work. Dr Khan said that he was grateful to the CQC for its advice on what he should do and that he took their advice. Asked about child protection and adult safeguarding policies, Dr Khan agreed that the surgery had none. Again, he said with regard to Dr Fernando that he was a qualified practising GP and was therefore presumably acceptable without such checks.

29. Dr Khan sought to show in his second witness statement that there was no reason for concern about the lack of these checks, because if they had been done the results would have been satisfactory. One of the documents exhibited to his second witness statement (p H46) was an Enhanced Criminal Record Certificate relating to Dr Fernando and dated 26th January 2011. Not only was that some four years old, it was also not in accordance with the current regulations. When this was put to Dr Khan, his response was that he thought it was the certificate required -- ' I am not a technical person, so I don't know '.

30. The bag containing the emergency medicine, said Dr Khan, was at the surgery at all times, though it was usually used for consultations at patients' homes. Many doctors had their own bags, but Dr Fernando did not, he relied on Dr Khan's. Dr Khan did not know when the lock jammed, but on the morning of 6th January he took it to a locksmith, but it could not be unlocked. However, said Dr Khan, it could easily be flipped open with a screwdriver. There was adrenalin available in a cupboard, the key to which was to be found in a drawer. He agreed that he had not previously mentioned the availability of the adrenalin in the cupboard.

31. With regard to Dr Fernando's use of his card to log in to the computer system, Dr Khan said very little other than that he accepted that it had happened. He did say that as he was precluded from involvement in patient care, he ' kept away as much as possible '.

32. Dr Fernando said in his witness statement that he was a GP of some 50 years standing. He met Dr Khan through an agency, started to work for him as a locum doctor in about the late summer of 2014 and had continued to do so. On starting work at the Granville Road surgery, Dr Fernando said, he was shown around the premises, but given no induction pack, an informal induction process common to many small practices.

33. Dr Fernando said that he saw no deficiency in the patients' notes and knew how to gain access to the medicines in the emergency bag. In case of difficulty, he could speak to the Practice Manager or to Dr Khan on his mobile phone. He knew how to deal with vulnerable patients, and knew what to do in the event of a fire. He had experience of dealing with emergencies.

43. Cross examined, Dr Fernando said that Dr Khan did not forewarn him of the inspection on 6th January 2015. He was acting locum doctor on that day but was not aware that Dr Khan had taken the emergency medicines bag to the locksmith, nor did he know that the lock was broken, nor that it could be opened with a screwdriver. Dr Fernando said that he had undergone child protection training, but he was aware neither of the level he had achieved nor of the level required. He did not recall the events of 17th November 2014 but said that it was not uncommon for one doctor to log in using another's card. He could not say for how long he had practised at Granville Road without a card of his own.

44. Drs Luqmaan Malik and Noor Ahmad each provided a short witness statement to the effect that Dr Khan's surgery gave no cause for concern and that there would have been no difficulty in responding to an emergency.

Counsel's submissions

45. Dr Fox, for Dr Khan, made the point that the deficiencies identified by the CQC did not justify suspension. He submitted that the CQC had overlooked or ignored. what would have been the appropriate remedy of imposing conditions - that step in the escalation of remedies had been omitted. Mr Macdonald, for the CQC, submitted that the evidence showed an overall lack of managerial insight. He cited a number of examples of breaches of regulations, many of them admitted by Dr Khan. Dr Khan relied on the CQC for guidance as a substitute for his lack of management.

The law

46. The suspension of Dr Khan's registration was under s.31 of the Health and Social Care Act 2008.
S.1 reads, " (1) if the Commission has reasonable cause to believe that unless it acts under this section any person will or may be exposed to the risk of harm, the Commission may, by giving notice in writing under this section to a person registered as a service provider or manager in respect of a regulated activity, provide for any decision of the Commission that is mentioned in subsection (2) to take effect from the time when the notice is given."
Subsection (2) defines those decisions and includes, "(b) a decision under section 18 to suspend the registration or extend a period of suspension."

S.18 empowers the Commission to suspend registration as a service provider or manager for a specified period.

The Tribunal's findings

47. The only major factual dispute related to the emergency medicines bag. It was undisputed that there was no mention in any of the preliminary discussion or correspondence at any time of any adrenalin available other than in the bag. The adrenalin alleged to be available in a cupboard was mentioned for the first time in evidence at the hearing.

48. Although Dr Fox appears to be correct in suggesting that adrenalin itself was not specifically mentioned in the CQC's enquiries, it was quite clear that those enquiries were directed to a great extent at emergency medication to deal with an anaphylactic reaction to an immunisation. The Tribunal agreed with Mr Macdonald's submission that any experienced GP must have known that the medication concerned was adrenalin.

49. In those circumstances it is curious to say the least that no mention was made by Dr Khan of the availability of adrenalin in the cupboard, the more so, perhaps, because Dr Richards who inspected the bag on 6th January, found no adrenalin in it.

50. The Tribunal considered it unlikely therefore, that there was adrenalin available in the cupboard. That may not be as important as it might seem, because even if there were adrenalin in the cupboard, Dr Fernando appeared to be unaware of it. He said that in an emergency he would have relied on the supply in the bag and, according to Dr Richards's unchallenged evidence, he would have been disappointed, even if he had been able to open it.

51. Whatever may have been the details of the circumstances, it is beyond doubt that there was not what there should have been, namely easy, well-known and established access to the appropriate medication in case of emergency.

52. That, in the Tribunal's view was indicative of Dr Khan's careless, passive and reactive approach to the management of his practice. Other examples were provided by the lack of any adequate induction procedure for new locum doctors, the absence of any Disclosure and Barring Service check, hepatitis status check or references, the lack of child protection or adult safeguarding policies and of adequate staff fire training.

53. As time at the hearing had been limited, and the issues which arose in 2014 had not been extensively explored, the Tribunal gave them little weight. Dr Fox emphasised that the 2015 breaches were different from those of the previous year, Mr Macdonald struggled to find merit in that. The Tribunal did not find it necessary to adjudicate upon that disagreement, it focused on what was observed at the inspection on 6th January 2015.

54. Those observations, as to which, with the exception of the emergency medicines bag, there was little factual dispute, satisfied the Tribunal that there

was, in Mr Macdonald words, an overall lack of managerial insight. That had resulted in numerous breaches of relevant regulations. Dr Fox sought to examine those breaches one by one, suggesting in relation to each that it did not justify suspension. He suggested, for example, that the use of an extension cable, even though not disclosed in any document as perhaps it should have been, was not a matter of gravity or significance. The Tribunal was not satisfied that that approach was the correct one. The question for the Tribunal was whether it had reasonable cause to believe that, at the date of the decision, any person would or might have been exposed to the risk of harm. The test of the reasonable belief is whether a reasonable person apprised of the law and the relevant information, would believe such a risk to exist.

55. No one is likely to be exposed to risk by the use of an extension cable, but the untidy wires under the Practice Manager's desk as illustrated by the appellant's photograph leave something to be desired. They are the least of a number of examples and consequences of poor administration of which the most serious was the absence of any proper arrangements to make emergency medication readily available. Between the two in gravity are a lack of procedures, checks, safeguards and records all intended to promote the smooth and safe running of a practice.

56. It was pointed out correctly on Dr Khan's behalf that his practice had run for a very long time without incident, and very few complaints. While that was undoubtedly true, it could not, in the Tribunal's view, convince the hypothetical reasonable person that the practice had been running without risk.

57. There were obvious risks arising from the appellant's casual approach to the management of his practice, which, as a result, was ill-equipped to deal with an emergency such as a fire or an anaphylactic reaction. The checks which Dr Khan had admittedly failed to carry out are provided for the purpose of protecting patients from risk. The conclusion that, in Dr Khan's practice, persons, patients and staff and doctors, were exposed to the risk of harm was inescapable. That risk would have continued without action on the part of the CQC.

58. Dr Khan's failure to appreciate that the regulations had an important purpose and that he had a duty to comply with at least the spirit of the law, if the letter of the law were beyond his grasp as a non-technical person, persuaded the Tribunal that the imposition of conditions would have been ineffective and that to protect from the risk of harm envisaged by s.31, there was no practical alternative to the suspension of his registration.

59. Accordingly, the Tribunal unanimously dismisses Dr Khan's appeal and confirms the CQC's decision of 8th January 2015 to suspend for four months his registration as a service provider at the Granville Road surgery.

Judge Andrew Lindqvist
Care Standards
First-tier Tribunal (Health Education and Social Care)

Date Issued: 30 March 2015