NCN: [2021] UKFTT 364 (HESC)

Care Standards

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

[2021] 4201.EA VKinly

Hearing held by video link
on 13, 14, 15 and 16 September 2021
Deliberation on 16 September 2021

Before

Ms S Brownlee (Tribunal Judge)
Dr David Cochran (Specialist Member)
Mr Matthew Turner (Specialist Member)

Dr Abbas Abdollahi

Appellant

-v-

Care Quality Commission

Respondent

DECISION

The Appeal

1. Dr Abbas Abdollahi ('the Appellant'), the registered provider at Elm Street Dental Surgery, 5 Elm Street, Ipswich, Suffolk, IP1 1EY ('the surgery') appeals pursuant to section 32 of the Health and Social Care Act 2008 ('the Act'), to the Tribunal. The appeal relates to a decision of the Care Quality Commission ('the Respondent') dated 7 January 2021 to cancel the registration of the Appellant in respect of the regulated activities of 'diagnostic and screening procedures', 'treatment of disease, disorder or injury' and 'surgical procedures'.

The Hearing

2. The hearing took place on 13, 14, 15 and 16 September 2021. This was a remote hearing which was not objected to by the parties in advance. The form of remote hearing was by Kinly CVP video. A face to face hearing was not held because it was not practicable, and no-one requested one. We considered that the issues in this appeal could be determined in a remote hearing. The

documents that we were referred to are in the electronic hearing bundle provided in advance of the hearing. Some participants were working from hard copy bundles and some from digital bundles. We also worked from one supplementary hearing bundle consisting of an updated Scott schedule, a document setting out matters remaining in dispute and the parties' skeleton arguments.

3. During the hearing, we received late evidence from the Appellant, namely an 'Elm Street Dental Practice Fire Risk Assessment' report from Mr Vinnie Gedge of FirePower dated 27 April 2021 and 'Elm Street Dental Surgery Rubber Dam Policy' dated 10 May 2021. We received the following evidence from the Respondent as a result of an oversight: the inspection report from the Care Quality Commission (CQC) dated 5 January 2021. We also received a link to the Government's guidance for employers in relation to employees on furlough (published on 26 March 2020, with no updates to the relevant section for our purposes), as a result of a line of questioning during the hearing. All of the documents received during the hearing met with no objection from either party. We considered them of relevance to the issues in the appeal and duly admitted them.

4. All participants were able to connect their video and audio for all of the hearing. Overall, no participants experienced significant connectivity issues – to such an extent that their engagement with the hearing was impacted. At the conclusion of the hearing, both legal representatives confirmed that they considered they had been able to engage with the appeal hearing effectively. Dr Abdollahi confirmed the same.

Attendance

5. Dr Abdollahi was represented by Ms Sunyana Sharma of counsel, instructed by Ms Laura Hannah of Stephensons Solicitors LLP. Dr Abdollahi gave oral evidence and called one witness: Mr Stephen Green, radiation protection adviser and director of Stephen Green & Associates. Ms Mary-Teresa Deignan of counsel, instructed by Ms Sarah Potter, solicitor at the CQC, represented the respondent. The Respondent called four witnesses: Mrs Patricia Cooper and Ms Janie Buchanan, CQC inspectors, Ms Caryn Reynolds, CQC specialist adviser and Ms Alison Currall, senior project manager at NHS England and Improvement East of England (NHSE). We had one additional witness statement from Ms Tracy-Jayne Norton, CQC inspection manager. There was no objection to her statement being admitted on the basis that she gave an overview of contact between Dr Abdollahi and the CQC.

6. There were observers at various points over the course of the public hearing and attendees from the legal teams of both parties, taking notes of the proceedings.

Background

7. Dr Abdollahi has been registered as a provider with 27 September 2011. The surgery was inspected by the Respondent on 24 February 2020 and 3

November 2020. At the inspections, the Respondent identified that the Appellant was failing to meet the requirements of Regulations 12 (safe care and treatment) and 17 (good governance) of the Health and Social Care Act (Regulated Activities) Regulations 2021 ('the Regulations'). On 3 March 2020, the Respondent issued a warning notice for Regulation 17 and on 8 April 2020, a requirement notice for Regulation 12. The second inspection did not occur until November 2020 due to the impact of Covid-19. Following the second inspection of 3 November 2020, on 18 November 2020, the Respondent issued a notice of proposal pursuant to section 17(1)(c) of the Act informing the Appellant that the CQC proposed cancellation of his registration of all three regulated activities. On 7 December 2020, the Appellant submitted written representations and supporting documents. On 7 January 2021, the Respondent issued a notice of decision, cancelling the Appellant's registration.

8. The Appellant was inspected on 23 April 2012 and non-compliance with Regulations 11, 12, 15 and 21 were identified. The follow up inspection of 5 September 2021 identified a continuing breach of Regulation 21 and new breaches of Regulations 10 and 11. On 8 October 2021, a warning notice was issued for ongoing breaches of Regulations 12 and 15. On 21 November 2012, compliance actions were issued for Regulations 12 and 20. At the follow up inspection of 28 February 2013, compliance actions were issued for Regulations 11 and 23. On 25 November 2013, continued breaches of Regulations 11 and 23 were identified and compliance actions issued. At a follow up inspection of 12 September 2014, the Appellant was meeting all standards. The new regulatory contact with the CQC came after the inspection of 24 February 2020.

9. On 4 February 2021, the Appellant lodged an appeal to the First-tier Tribunal against the decision to cancel his registration. On 2 March 2021, the Appellant was contacted to inform him of a focused inspection planned for 8 March 2021. The Respondent noted some improvements as a result of the inspection of 8 March 2021 but ultimately concluded there were continuing breaches of Regulations 12 and 17 of the Act.

Legal Framework

10. Section 3 of the Act invests in the Respondent registration functions under Chapter 2.

11. By virtue of section 3(1) of the Act, the Respondent's main objective is to protect and promote the health, safety and welfare of the people who use the health and social care services.

12. Section 4 of the 2008 Act sets out the matters to which the Respondent must have regard, including the views expressed by or on behalf of the members of the public about health and social care services, experiences of people who use the health and social care services and their families and friends and the need to protect and promote the rights of people who use health and social care services. Any action taken by the Respondent is proportionate to the risks against which it would afford safeguards and is targeted only where it is needed.

13. Section 17 of the 2008 Act gives the CQC the power to cancel the registration of a service provider of a regulated activity on the grounds that the regulated activity is being or has at any time been carried on otherwise than in accordance with the relevant requirements. Relevant requirements include any conditions imposed by or under Chapter 2 and the requirements of any other enactments which appear to be relevant to the Respondent – i.e. the 2008 Regulations.

14. Under section 20 of the 2008 Act, the Secretary of State is empowered to make regulations in relation to the regulated activities by way of regulations. The Regulations made under this section are the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, SI 2014/2936 ('the Regulations') and The CQC (Registration) Regulations 2009.

15. Sections 26, 27 and 28 of the Act set out the procedural requirements in relation to notification of the Respondent's decision.

16. Section 32 of the Act provides for a right of appeal to this Tribunal against a decision to cancel the registration of a service provider in relation to a regulated activity. The Tribunal may confirm the decision or direct that it is not to have effect, or it can vary, cancel or impose any conditions on the registration that it sees fit.

17. Part 3 of the Regulations sets out the Fundamental Standards that registered providers must comply with when carrying on a regulated activity. This appeal concerns two of them – Regulations 12 and 17.

18. The Respondent bears the burden of persuading the Tribunal that cancellation of the provider's registration is a proportionate decision as at the time of the appeal hearing. The Respondent must establish the disputed facts upon which it relies to support satisfaction of the proportionality of the decision on the balance of probabilities.

19. The Tribunal is required to determine the matter afresh and make its own decision on the merits and evidence as of the date of hearing and should take into account evidence which post-dates the notice of decision (subject to fair notice).

Issues

20. The key question for the Tribunal is whether the Respondent is able to demonstrate, on the balance of probabilities, that the decision to cancel the registration of the Appellant remains a proportionate and reasonable one, when considered alongside the requirements in sections 3, 4 and 17 of the Act.

21. We had helpful skeleton arguments from both parties, which we considered in advance of the hearing and as part of our deliberation.

The Appellant's position

22. The Appellant has accepted many of the breaches found during the three inspections of February and November 2020 and March 2021. The Appellant contends that he has worked responsively to address the failures and has managed to put in place a number of improvements to such an extent that he is no longer in significant breach of Regulations 12 and 17. Ultimately, the Appellant does not accept that the service remains in substantial breach of Regulations 12 and 17, considers that the Respondent has failed to give any or sufficient weight to the improvements made to the surgery and has failed to acknowledge the improvements so as to alter the overall rating to the surgery. The Appellant is also clear that with more time, the surgery will be able to achieve a better rating, once the improvements implemented or planned by Dr Abdollahi are in action, in a reopened surgery and with potential for support from an associate dentist, such as his son.

23. At this point in time, Dr Abdollahi is the subject of an interim suspension order, imposed by the General Dental Council on 18 March 2021, which prohibits the Appellant from practising as a dentist, but does not prohibit him for registration as a provider with the CQC or from making changes in response to the inspection of 8 March 2021.

24. The Appellant requests that the Tribunal should direct that the decision to cancel should cease to have effect.

The Respondent's position

25. The Respondent submits that the decision to cancel the Appellant's registration should be confirmed, as a decision that remains justified, reasonable and proportionate given the Appellant's poor history of compliance with the requirements of the Act and the Regulations, particularly since February 2020. The Respondent further submits that the evidence presented of the improvements made since the first inspection in 2020 is not sufficient to engender confidence in the Appellant to be able to provide safe and effective care in a well-led and governed surgery in the future. The Respondent presented three themes to support its position: delays in responding to concerns, as well as incomplete and inaccurate responses.

Evidence

26. We considered all the evidence that was presented in the hearing bundle and during the hearing. We have summarised the evidence insofar as it relates to the relevant issues for the Tribunal. What is set out below is not a reflection of everything that was said or presented at the hearing or in the hearing bundle.

27. We heard oral evidence from Mrs Cooper, Ms Buchanan, Ms Reynolds, Ms Currall, Mr Green and Dr Abdollahi. We also carefully considered the witness statements of those witnesses, as well as Ms Norton, taking into account the fact that she did not attend the hearing to answer questions and have her evidence tested and balancing that against the fact that her evidence did not go directly to any of the areas subject to factual dispute.

28. Mrs Cooper was the lead inspector on 24 February 2020. She observed that the first time she had been made aware of the Appellant's technique for using dental floss to secure instruments during root canal treatments was when she saw the matters in dispute. She noted that there was not mention of a rubber dam policy at her inspection and staff had no knowledge about fire drills, upon her questioning of them. She also noted that the Appellant provided very vague answers and was unable to tell her where the policies were located. There was no evidence that any of the policies, once presented to her, had been reviewed since 2015 and there were some that were not relevant to the surgery. She observed that staff could not give her clear answers and she was presented with a very large A4 box file full of policies and procedures – she struggled to find anything and wondered how staff would manage, particularly in a situation where access to the policies was urgently needed. She saw dental burrs loose in drawers, rolling around and open to contamination every time the drawers were opened.

29. She had no difficulty in following the Appellant in discussions with him at the inspection. She took her time and her dental adviser was very supportive with Dr Abdollahi, giving him tips about the storage of Glucagon and directing him to lots of publicly available guidance. Mrs Cooper had no concerns about Dr Abdollahi understanding her and she felt he was following everything she said to him. She was clear that she heard him say that he did not use dental dams as patients did not like them. She noted that she sent the draft report to him on 5 March 2020 and emailed him on 25 March to ask for his factual inaccuracies. He did not challenge any of the details in the draft report.

30. Ms Buchanan stated that she was wary of there being room for misunderstanding when it came to communicating with Dr Abdollahi and so she asked a 'bog standard' question about the duty of candour. She observed that by the time of the March 2021 inspection, the Appellant had been asked about the duty of candour twice before and she would have expected him to know about it, given that it has been a regulation since 2018. She asked to see the sharps risk assessment several times and he just brough the sharps policy. He could not find the sharps risk assessment – a document she still had not seen by the time of the hearing.

31. At the time of November 2020, the staff explained that they had never practised an upper floor evacuation and she noted that the logbook was not fit for purpose. This had been pointed out as a concern on the last inspection and she was concerned to see it was still an issue at the two inspections on which she led. She noted that every single evacuation was taking two minutes and they were still being undertaken when the surgery was closed and there were not as many people in the building – with the time still being recorded as two minutes. She undertook a walk-through of the evacuation on one of the inspections and noted that it took her 11 seconds.

32. She continued to have concerns about the infection control areas, noting that the cleaning schedule record was not fit for purpose as it was just a series of ticks, ticks against rooms which did not exist and a room that was not in use. She criticised the document as not technical, lacking anyone who held

accountability for it and not demonstrating that good cleaning procedures had bene undertaken.

33. At the November 2020 inspection, she had concerns about the method for recording used prescription pads. In her words, there was no system in place and so certainly not one that would allow for easy and ready audit and identification of missing prescription pads. This was in the context of a surgery where the nurses who hand the prescription pads to Dr Abdollahi – they were not always in his control.

34. The team meeting notes gave her cause for concern – they were of a poor quality and did not demonstrate with adequate detail what was being discussed at the team meetings. There was no documented evidence that infection control was being discussed at team meetings, only Dr Abdollahi's assertion. There was one record of a team meeting having taken place in November 2020 in which a total of 33 policies had been recorded as having been discussed with the team, including policies which have not been shared with the Respondent or the Tribunal panel on appeal. Ms Buchanan had concerns with the team's ability to read 33 policies in one day, as well as digesting them and being able to discuss them all at a team meeting.

35. By the third inspection in March 2021, she asked one staff member about the duty of candour and the staff member was not aware of the duty. This post dated the team meeting during which that policy had been discussed. She explained at Dr Abdollahi answered the question by explaining that it was about ensuring that things are kept clean. She did not get a sense that he could not understand her. She asked to see the duty of candour policy, which was referred to in the team meeting minutes from November 2020 and he did not provide one. The first duty of candour policy Mrs Buchanan saw was the one submitted as part of the appeal – dated 10 May 2021.

36. Ms Buchanan did not accept that Covid-19 provided a valid reason for the lack of adequate progress with improvements between February 2020 and March 2021. She stated that many dental practices have used the period of closure (from approximately March 2020 to 8 June 2020) to make improvements as it provided a good opportunity. She did not accept, when put to her, that Dr Abdollahi could not train his staff during that period as they were on furlough. The Tribunal was provided with public guidance on this point which indicated that furloughed staff could be asked by employers to complete training. This point was not taken any further. Ms Buchanan explained that the CQC had considered the impact of Covid-19. The notice of decision dated 7 January 2021 sets out that the CQC did consider Covid-19 in reaching its decision. She took the view that action should have been taken sooner that it was taken, noting that he had received additional time to make improvements – eight months between February and November 2020. She observed some improvements but did not consider he could sustain that process.

37. In cross examination, Ms Buchanan was asked about her demeanour and it was suggested that she was brash and aggressive with Dr Abdollahi. Furthermore, it was suggested that she had thrown a folder of documents

across the table. This was not corroborated by Mrs Reynolds, who had conducted both inspections with Ms Buchanan. It was also noted that this account did not appear in either of Dr Abdollahi's witness statements to the Tribunal and it was the first time it had been raised. Ms Buchanan did not accept this at all. It was further suggested for the first time that Ms Buchanan had threatened Dr Abdollahi with closure and asked him if he thought she was a racist. In addition, it was suggested that she had an accent that was difficult for Dr Abdollahi to understand. Ms Buchanan observed that if the Appellant had difficulties in understanding her, he did not indicate this at any of the two inspections and she could not understand why he would think she had threatened him and thought she had thrown a folder across the table and been brash with him. Finally, she made the point that no complaint has ever been raised about her conduct and Dr Abdollahi had not raised this as a concern at the time or as part of the CQC separate complaints process.

38. Ms Buchanan explained that the Appellant clearly did not understand the seriousness of the warning notice issued in March 2020. She explained to him that he should look at the CQC's enforcement policies on its website, noting that it was in nobody's interest to have a situation where the parties ended up at an appeal hearing.

39. Mrs Reynolds attended the inspections of November 2020 and March 2021 with Ms Buchanan. She explained that rubber dams must be used in all root canal treatments and if they are not going to be used, there should be a clear risk assessment recoding the reasons why and the steps taken to mitigate the risk. In her experience of 20 years of professional practice, she has never had a patient who refused a dental dam once its use was explained to them. She also explained that from a medico-legal perspective, a dentist would not be covered for performing a root canal treatment without a dental dam in place. She explained that the Appellant was working from a starting point of reasons not to use a dental dam and that was the wrong way round, in her professional opinion. She was not shown a rubber dam policy on or after each of the inspections. Dr Abdollahi produced a rubber dam policy dated 10 May 2021 during Mrs Reynolds' oral evidence. She was given time to review it as it was the first time she had seen it. She did not consider it fit for purpose – noting that it did not contain a risk assessment document for times when a dental dam would not be used, which, on Dr Abdollahi's account, appeared to be often. She could not understand why it had not been provided at any earlier stage and noted that it did not reflect the practice she saw during the inspections. Mrs Reynolds stated that she had reviewed the notes for one patient was returning for root canal treatment and there were no references to rubber dams.

40. At the inspections, she was not shown any radiograph audits and did not seem to understand the difference between dip slide and protein testing – which she characterised a professionally embarrassing and something which was putting people at risk. The radiograph audits she had reviewed in the hearing bundle were substandard and did not provide any evidence of learning and an action plan to improve the grades. She noted undated instruments, so there was no way of understanding if they were sterile. She could not find any long-handled brushes for the manual scrubbing of the instruments and noted that Dr

Abdollahi did not draw her attention to another cupboard or area where the long-handled brushes were located. She explained that the risk of an inoculation injury is increased if staff are not using long-handled brushes. Dr Abdollahi was not able to answer her questions as to antibiotics prescribing – seeming to be confused about what he would prescribe and indicating that he would prescribe for seven days, which, in her view, was on breach of guidelines. She asked him about the duty of candour on 3 November 2020 and he was unaware of it.

41. She was further concerned to note that there were no records which reassured her that Dr Abdollahi was calculating fallow times between aerosol producing consultations for patients – a point which was more important in the period during which the surgery was open and the pandemic was ongoing. She took the view that because there were incorrect details in his cross-infection audits, that invalidated them and they were not reliable. She also noted that he submitted an Irish policy on infection control, which did not reassure her of his knowledge of the guidelines he must follow for practice in England.

42. Mrs Reynolds did not accept that Ms Buchanan had done anything other than be professional and try to help the Appellant during the inspections. She did not witness Ms Buchanan throwing documents and noted that she has completed multiple inspections with Ms Buchanan and found her to be respectful and professional. She disagreed that Dr Abdollahi was difficult to understand. She was able to ask professional queries and she understood all of the answers the Appellant provided. Mrs Reynolds observed that if she had not been able to understand him or vice versa, this would have led to different concerns from her.

43. From her perspective, the Appellant made minor improvements and only after the CQC had been in the inspect. She noted that the first inspection took place before closure due to Covid-19 and considered that the Appellant was not committed to compliance as some of the issues were major and could potentially affect patient safety in a significant way.

44. Dr Abdollahi explained that he did not understand the warning letter of March 2020. He believed he had put in place actions straightaway and he did not understand that the CQC could take away his registration, saying that it was an unexpected decision. He explained the effect that Covid-19 had had on him. He had responsibility for his family and his staff, who are like family to him. His father in law passed away after an illness and his wife wanted to travel to Tehran and tried to book flights on three occasions, but the family decided it was best that she did not travel due to her own health. Dr Abdollahi also has a son in Budapest – away from the family during the pandemic. In the end, the family could not attend the funeral of his wife's father in Tehran, which clearly distressed the appellant. The surgery closed on 23 March 2020 and reopened on 5 November 2020. The surgery closed again on 18 March 2021. Dr Abdollahi explained that he is more than happy to do everything to make the surgery safe for people. His aim is to make it safe for people and to improve his business and comply with everything the CQC requires from him. He was clear that he is happy to do this. He found the inspection process stressful, as

did his staff. He felt that everyone was running around during the second inspection and Ms Buchanan was not happy, did not ask him questions and did not speak to him. He then went on to say that Ms Buchanan told him he was going to get into trouble and he said that he did not understand. He found Mrs Cooper to be nicer than Ms Buchanan. He stated that he had a hard accent to understand and that he found Ms Buchanan's accent nice but it was a little bit difficult for him to understand her.

45. The Appellant set out the effect cancellation of his registration would have on him. It has already had an effect on him – affecting his sleep and making problems for his health, his family and for him. He explained that his surgery is his life and he has invested his life in it.

46. He explained that he did not use rubber dams, but ensured he used other techniques, in the absence of dams – such as tying dental floss to the hand pieces so they would not drop into the patient's mouth during the root canal treatment and using cotton rolls and suction to minimise saliva which could cause contamination of the root canal.

47. He stated that he had complied with some of the requirements from Mr Gedge in the fire risk assessment of 27 April 2021. He indicated that he would comply with the remaining requirements before the surgery would reopen. He explained that he does not understand what is meant by 'local standards for invasive procedures'. He also indicated that he did not understand what was meant by a 'bar' of soap. He accepted that his audits were not always correct, but he was hoping to learn.

48. He explained that Dental Compliance was going to help him plan what he is going to do in the future with regards to appraisals and he accepted that he had not recorded any staff appraisals since the surgery had opened in 2011, but he was going to be able to complete them with the support of Dental Compliance. He explained that Mr Davies is going to help him with the weekly checks of legionella, still not realising, it would seem, that he is required to conduct biweekly legionella checks. He showed the Tribunal panel that he now used an electronic diary reminder system, which looked similar to an Outlook calendar screenshot of recurring meetings, including meetings taking place while the surgery was shut (in May 2021) and on the weekends.

49. The Appellant explained that he would like to take on an associate at the surgery, but he has not found someone suitable since the last one left in 2013/2014. He would like to have less responsibility for the policies and procedures of the surgery and concentrate on his dentistry. He would like to involve his son in the surgery. Dr Abdollahi confirmed that he is not a member of the British Dental Association (BDA) and did not know he could get help and support from the BDA. He is not a member of the Faculty of General Dental Practice (FGDP) either and was not aware of their guidelines as to safe antibiotic prescribing. He followed his own guidance and discussed clinical matters with friends. He was not able to direct the Tribunal panel to any guidance which allowed for dentists to prescribe antibiotics for seven days, as was his practice.

50. Mr Green confirmed that there was no evidence of compliance with the two sets of regulations in relation to safe radiation use between February 2018 and his company's involvement in January 2021.

The Tribunal's conclusions with reasons

51. Dealing with the factual matters which remained in dispute, as set in the Scott schedule. We noted that Dr Abdollahi made a number of further admissions at the beginning of the hearing. Broadly speaking, Dr Abdollahi accepted there had been failures which led to the breaches of the Regulations in February 2020, but there had been some improvements by November 2020, notwithstanding the impact of Covid-19 and further improvements by the time of the third inspection in March 2021.

52. As a starting point, we considered Dr Abdollahi's concerns about people's ability to understand him, bearing in mind, on his own account, English is his second language. The Tribunal panel observed Dr Abdollahi carefully throughout his oral evidence and carefully reviewed the various policies he had drafted. The Tribunal concluded, without hesitation, that he is easy to understand and we were able to follow his oral evidence with ease. We noted that he indicated that he found Ms Buchanan difficult to understand, at times, due to her accent. However, Dr Cochran asked Dr Abdollahi a number of questions during his oral evidence and he did not display any difficulty in following Dr Cochran, who has a Scottish accent which is not unlike Ms Buchanan's. Furthermore, we found it difficult to accept that at times Dr Abdollahi could not understand Ms Buchanan and then, seemingly, at other points, he was able to understand that she threatened him and asked him if he thought she was racist. From a credibility perspective, we found it unusual to note that the Appellant did not raise any concern about Ms Buchanan at any stage, including in his two detailed witness statements to the Tribunal. The first time the Tribunal and Ms Buchanan became aware of her apparent brusqueness, threat to the appellant, throwing documents across a table and asking him about racism was during cross examination. We noted the reaction of Ms Buchanan to these accusations – she became visibly flushed and unsettled by the questions and took time overnight to reflect and maintained her position that she extremely surprised and was adamant that she had not done any of the things suggested to her. We found Ms Buchanan to be a credible witness who reacted with genuine shock to having her integrity questioned. We did not conclude that she acted in the manner suggested by Dr Abdollahi. She came across as a forensic highly professional and fair witness, who provided a consistent account of what she witnessed during the two inspections of November 2020 and March 2021. We noted that recipients of regulatory action letters are invited to notify the CQC of any concerns they have and at no point prior to cross examination did the Appellant raise any concerns. Furthermore, we considered the oral evidence of Mrs Reynolds on this point, who was vehement in her position that Ms Buchanan is professional and supportive. Perhaps the most compelling point on this issue came directly from Ms Buchanan when she reflected that in her many years of experience as an inspector, she knew that the process could be stressful and it would be

counterproductive for an inspector to be brash or to act in an unprofessional and unhelpful manner. We noted that this comment supported our conclusion on Ms Buchanan – that she was a highly professional, attentive and diligent witness who acted with integrity in the giving of her evidence and

53. We found the three CQC inspectors to be credible witnesses and found that their evidence was supported throughout by the documentation. We were particularly impressed with the oral evidence from Ms Buchanan and Mrs Reynolds, which was highly relevant to our role in assessing whether the decision to cancel registration remained a proportionate one as of today. We had the benefit of their detailed observations and findings from the inspections of November 2020 and March 2021, as well as their comments on points made by the Appellant in his two statements and the documents he submitted with them. We took into account the Appellant's two witness statements, exhibits to them and his position on the numerous allegations in the Scott schedule – he accepted a significant number of failures and criticisms arising from the three inspections.

54. We did not accept the Appellant's explanation that he uses dental dams in line with guidance. There was no documentary evidence presented to support the Appellant's position that when he did not use a rubber dam for a root canal treatment, he would record the mitigating steps he took in the alternative, including tying a length of dental floss to the handle of the root canal. This explanation was not provided prior to the Appellant's responses to the Scott schedule. We considered Dr Abdollahi's evidence that he took various steps to ensure risk was limited, including use of suction and cotton roll, but we did not find this acceptable to meet the requirements of the guidance from the British Endodontic Society and noted the overarching concern of Mrs Reynolds that if a patient refused a dental dam, the procedure should not be carried out. Finally, we noted that the Appellant provided a policy dated 10 May 2021 during the hearing and did not receive an explanation as to why this was not submitted at an earlier stage. Mrs Reynolds took the view that the policy was lacking and not in line with requirements. Furthermore, the Appellant did not provide a copy of the risk assessment he said he would implement in the future.

55. We noted that on a number of issues, the Appellant explained that there may not be documents to demonstrate that he completed actions, but they still occurred. This was put forward as his position on validation testing of the autoclave. However, we concluded that in the absence of documentation to demonstrate the testing was taking place prior to using the autoclave, we could not be satisfied that it was more likely than not that the testing was taking place.

56. We noted the Appellant's position that there was no record of a fire risk assessment prior to the one of 27 April 2021. However, we took into account that the actions required by Mr Gedge had not yet been completed in full. We were not satisfied as to the documentary evidence of the fire drills which were taking place on a weekly basis when the surgery reopened and during the time when it has been closed (since 18 March 2021). We accepted Ms Buchanan's

evidence that the records of the fire drills were inadequate as there was no understanding of what was undertaken during the drills and the reason why every evacuation took two minutes irrespective of the number of people present. We accepted the evidence from Mrs Cooper and Ms Buchanan that staff did not have an awareness of what was required in the event of a fire and we were not presented with any evidence to set out what training had been undertaken by the staff, what areas had been covered and what the expectations for the staff were in the event of a fire.

57. The Appellant accepted in his oral evidence that he is not aware of local safety standards for invasive procedures. In addition, he provided no evidence to support his position that his knowledge on antibiotic prescribing was in line with current guidance, including on his view that antibiotics would be prescribed for seven days. We noted his evidence that he is not a member of the BDA or the FGDP or, it would seem, any professional body for dentists practising in England/the UK; he takes professional input from 'friends'. We were not satisfied that the Appellant possesses sufficient knowledge on prescribing with is in line with current requirements for dentists, given the guidance we had cause to examine, which runs counter to Dr Abdollahi's practice. We were also not satisfied that the Appellant has put in place a sufficiently robust system for recording and auditing the prescription forms that he uses. His current system is still inadequate and leaving him open to risk, in that it does not allow for quick and clear identification of missing prescription forms. This is especially concerning, from a risk perspective, given that the Appellant is the only staff member at the surgery who has prescribing rights.

58. We have accepted the evidence of Mrs Cooper. She provided clear evidence that at the February 2020 inspection, she could not locate medications to manage severe allergic reactions and seizures, as well as to relieve the symptoms of asthma and COPD. The Appellant asserted that the medications had been 'ordered in' and were in the surgery, she just didn't see them. This was a theme from the Appellant at various points in his evidence. We noted that in respect of the collimator on the x-ray machine, we received photographs of that. We did not have photographs or any other evidence to support Dr Abdollahi's assertion that the items were present in the surgery, they just weren't seen by the inspectors. We took into account the correspondence which went between the parties after each inspection, which included the opportunity to raise factual objections to each draft inspection report. We took into account that at the end of each inspection, an oral summary of feedback was provided to the appellant. We concluded that in that set of circumstances, there have been opportunities to raise concerns and provided evidence to support the Appellant's position, including in preparation for this appeal hearing, which have not been taken up by the Appellant. We concluded that the reasonable inference to draw was that the Appellant's explanation is not a plausible one in response to the clear evidence from the witness.

59. As to safety alerts being available in the surgery, the Appellant accepted this at the beginning of the hearing. We noted the lack of documentary evidence to demonstrate the existence of an 'alerts folder'. As to radiograph audits, the Appellant started from a position of accepting that at the time of the February

2020 inspection, his process and records as to audits was severely lacking in minimum requirements. However, the Appellant does not accept that there was no record of a radiographic audit having taken place after 12 April 2012. The Appellant's position is that the audits took place yearly, which he accepts was not frequent enough. We do not accept that the audits took place every year as we have broadly accepted a key principle, which was referred to by the three CQC inspectors who provided oral evidence – if something is not recorded, then it did not happen.

60. We now turn to the issue of the presence of rectangular collimators on the x-ray machines. Ms Buchanan and Mrs Reynolds were clear and consistent in their evidence – they were not present at the inspection of 3 November 2020. The Appellant has been clear, from the point of his first witness statement for this appeal, that the collimators were in place on the day. We carefully considered the photographs submitted to demonstrate this, which are undated. They were of limited assistance to us, as was the Appellant's assertion. We concluded that if that had been a factual inaccuracy in the report issued after the November 2020 inspection, it would be reasonable to expect that Dr Abdollahi would engage to correct that position and provide evidence at that point. This was in the context of the first inspection, which resulted in a requirement and a warning notice being issued to him. We ultimately preferred the evidence from the two CQC inspectors on this point and have concluded that there were no collimators in place on the day in question.

61. Mrs Reynolds provided clear evidence that she observed bagged instruments with no dates on them. Again, we find it difficult to accept the Appellant's position on this as he did not raise any concerns with the accuracy of this position during the inspection process. We understand the point made on Dr Abdollahi's behalf, that he found the process of inspection stressful and did not understand the severity of the action being taken. We have carefully read the communications from the Respondent on the action it took as a result of the inspection of February 2020. We have also taken into account that the follow up inspection was postponed (due to Covid-19) from March 2020 until November 2020, giving the Appellant further time to consider the communications and, if he was having difficulty with understanding them, to take advice and input from someone. Having observed Dr Abdollahi during the hearing, particularly in giving his oral evidence, we accept that at times he needed appropriate time to process a question and/or turn up a document (as he was working from two separate hard copy bundles). However, we did not observe a person who did not understand the questions being asked of him, to the extent that he often tried to anticipate where the line of questioning was going and provided detailed responses, which went beyond the scope of the question. In the Tribunal panel's view, this did not support the suggestion from the Appellant that he did not understand the process. We consider that he was provided with reasonable time, detailed information and pointers to other sources of information to ensure he was prepared for each announced inspection. To the end, we have accepted that some instruments were not dated. We have adopted the same approach in relation to the long-handled brushes. In the absence of any evidence beyond Dr Abdollahi's assertion and in the presence of clear evidence from Mrs Reynolds as to the search she

undertook and the location of the cleaning tools, we have concluded that it was more likely than not that there were no long handled brushes on the premises.

62. Mrs Reynolds was clear in her evidence that the Appellant did not provide a correct response to what he would prescribe for a common dental infection. The Appellant's evidence was unconvincing on his knowledge base and the guidelines he is following. We conclude that he did not provide an appropriate response to Mrs Reynolds on 3 November 2020. We understand the position from the Appellant that he now possesses an understanding of the duty of candour. We carefully considered Ms Buchanan's evidence as to the attempts she made to make the question to him as simple or 'bog standard; as possible and his failure to provide an accurate response. We have no doubt that Dr Abdollahi did not understand the concept of the duty of candour in November 2020 and in March 2021 and this was not through a misunderstanding of the question posed, it was through a lack of knowledge on an important regulation in place for all healthcare providers since 2015. We have accepted Ms Buchanan's evidence as to the Appellant being unable to demonstrate an appropriate understanding of the difference between a risk assessment and a policy at the inspection of March 2021. We noted his responses in oral evidence, which demonstrated some understanding of the differences, but clearly not enough, given that in the course of the hearing we received a rubber dam policy dated 10 May 2021, with no associated risk assessment (as one is not in place). We did not accept the Appellant's position that he misunderstood the question from Ms Buchanan. As we have previously concluded, the Appellant was able to follow the questions being put to him by both legal representatives and the Tribunal panel. Ms Buchanan was a clear, fluent communicator who used plain English in her responses to questions. We did not consider that her 'accent' acted as a barrier to understanding her, in the same way as it did not for Dr Abdollahi.

63. As to the fallow times, the Appellant asserted that he took into account the need for appropriate gaps between aerosol producing procedures. He was unable to demonstrate his calculation for this or his process and provided no documentary evidence to support it – we simply had to take his word for it, which was then considered alongside his recording of appointments without appropriate gaps for fallow times between the appointments. We considered Dr Abdollahi's evidence to be unconvincing on this. Again, we had his explanation in evidence with no documentary evidence to support the process that was actually in place at a crucial time during a pandemic and when dental practices/surgeries could reopen, subject to carful infection controls. Accordingly, we have concluded that it was more likely than not that the Appellant was not following the recommended fallow times, borne out in a record of appropriate calculations.

64. We noted the Appellant's acceptance, at the start of the appeal hearing, that there was no legionella lead in place as of 24 February 2020.

65. As to the health and safety policy and procedures for health and safety risk assessment in practice. Again, the Appellant has asserted that they were in place and contained in a folder which he provided at the inspection of 24

February 2020. We have not been provided with copies of the documents and we have noted the failures from the Appellant in relation to his registration with the Health and Safety Executive which demonstrate a fundamental lack of understanding about his legal obligations. In light of this, in combination with the clear evidence from Mrs Cooper on this point, we consider it more likely than not that the policy and procedures were not present at that time. That leads to the reasonable conclusion that his staff were not able to confirm their whereabouts as they had no knowledge of their existence at that time and the reasonable conclusion is that they were simply not in place. We reached the same conclusion in relation to the risk assessments for control of substances hazardous to health – risk assessments which were not provided to the Tribunal panel.

66. As to dental burrs, the Appellant demonstrates, in his response, a lack of understanding of the issue. The issue was that the dental burrs were stored loosely, simply wrapped in paper towels and able to move around the drawer, with exposure to the environment every time the drawer was opened. There would have been no difficulty with storage in one drawer, as long as the burrs were stored appropriately within the drawer.

67. As to 3 November 2020 inspection, we accepted the evidence from Dr Abdollahi that fire drills were not taking place due to the surgery being closed. He has recorded that position in the fire 'logbook' submitted in the hearing bundle. We do not consider it to be a valid concern – the fact that fire drills had not been taking place prior to the inspection of 3 November 2020, given that the surgery had voluntarily closed in March 2020 and did not reopen until the start of November 2020.

68. As to the Appellant's understanding of cross infection control, he submitted an audit he carried out on 10 May 2021 (exhibit AA/11). In his evidence, he accepted that he had answered incorrectly on some of the questions in the audit. We had real concerns with this. The audit was supposed to demonstrate that the Appellant now has a clear understanding of what is required for appropriate infection control and yet due to inputting inaccurate information, we took the view, as put forward by Ms Buchanan, that the audit cannot be relied upon as an accurate and up to date record. In effect, it would need to be completed again. The Respondent's concerns as to the audit were made clear to the Appellant in Mrs Reynolds' second witness statement dated 8 June 2021. It was open to the Appellant to conduct a new audit and yet there was no evidence before us of one having been conducted, taking into account that the inaccurate audit was conducted on 10 May 2021 – at a time when the surgery was closed. We have no reasonable explanation from the Appellant as to why a new one was not undertaken, and this leaves us to conclude that the Appellant is still not able to demonstrate an acceptable understanding of the importance of an accurate audit of infection control. This is supported by the fact that he asserted, in the Scott schedule, that he had now conducted an appropriate infection control audit and relied on exhibit AA/50, which is an infection control policy dated 16 November 2020. This is concerning, in that it does not engender any confidence that he now understands what is required of him as a registered provider.

69. There is no documentary evidence before the Tribunal panel to demonstrate that infection control was discussed as a 'rolling item' at each team meeting. We have reviewed the team meeting minutes from 22 February 2021, 9 September 2020 and 14 February 2020 (exhibit JB/08), which are completely lacking in detail, agreed action points and dates by which the actions would be completed or followed up. The meeting minutes make little sense and provide no helpful detail on the discussion points. We have readily concluded that infection control was not a rolling item on the team meetings, not least as we have little clear idea of the frequency of the meetings, the form they took and the attendance and engagement from the staff.

70. We have taken into account the explanations from Dr Abdollahi was to why there were regulatory breaches with the surgery. He cited his personal difficulties with Covid-19 and we have no doubt that in his personal life, he was dealing with times of real stress and anxiety, to which we are sympathetic. However, there was no bar on him making the CQC aware of this and it would appear that the Respondent took Covid-19 into account, as it expressly set out that it did in the notification of decision letter dated 7 January 2021. Furthermore, we have to balance Dr Abdollahi's personal circumstances against the regulatory requirements all registered providers are expected to meet and maintain. We took into account the amount of time he has had to make substantial improvements to the surgery, which included a number of months in 2020 when the surgery was closed and the Respondent had made a decision to delay the follow up inspection from March 2020 to November 2020 – a period of eight months to either make the significant improvements required, including coming into legislative compliance in relation to radiation and health and safety. We were concerned with the Appellant's approach, as it did not provide reassurance that he is able to embed effective governance – in relation to understanding his regulatory responsibilities. He explained that he did not understand the consequences of the warning and requirement notices he received in March 2020. This troubled us as not understanding is one thing but doing nothing to alert the Respondent to this and to seek assistance in understanding his requirements is quite another. This does not provide any reassurance to the Tribunal panel that the Appellant understand good governance, when it is considered alongside the improvements he has made, including a screenshot of a number of recurring reminders from May 2021, some of which take place on the weekend. This evidence is lacking as it does not articulate that the process is for each of the reminders. This concern was supported by the Appellant's evidence as to team meetings, which was not particularly clear, but seemed to amount to a telephone discussion with each of his team members.

71. We noted the remedial plan which the Appellant provided to the Respondent in November 2020. We had no update on this plan, which would have been reasonable to expect, given the Respondent's follow up inspection of March 2021, in which it still noted breaches of Regulations 12 and 17 and maintained its position that cancellation remained a reasonable response to the continued breaches. We would have expected to see a clear plan for improvement, with responsibility for each improvement set out and the priority it was being given,

as well as a risk rating and a clear timeline for completion. We were not persuaded by the reliance upon external bodies to assist Dr Abdollahi in ensuring and maintaining compliance – there was no clear information before us as to what was planned. The Appellant said, in his oral evidence, that he would do whatever he was told to do. However, there was insufficient evidence that he could do what was required between February 2020 and the day of the appeal hearing, so it left the Tribunal panel with the conclusion that it could not be satisfied that it was more likely than not that moving forward, the Appellant would be able to come into full compliance and to remain in compliance with Regulations 12 and 17. As one example, we noted that the Appellant still does not appear to understand the requirements in relation to legionella management, as a closed premises, which requires twice weekly testing of the water. This is still not happening or if it is, it is not being evidenced. The lack of documentary evidence to support the position that things were actually taking place was a real concern for this Tribunal panel. Good governance requires effective systems which are subject to audit in order to improve practice and guide learning and improvement for all relevant staff, including the Appellant. We did not consider that we had sufficient evidence before us to demonstrate that the systems had now improved to such an extent that there would be compliance with minimum standards in line with current guidance and that the documentation generated to demonstrate this would be in place, moving forward.

72. Overall, we considered the evidence from the three inspectors called by the Respondent was persuasive and clearly demonstrated the rationale for the outcomes of the three inspections. The inspectors applied their policy and process correctly and completed their work in a diligent manner. We considered the decision tree and enforcement policy used by the Respondent in its management review meetings. In the case of the Appellant, through a series of positive indicators being engaged, the decision tree necessarily placed the decision in the more serious end for the purposes of the ultimate decision maker.

73. The Tribunal reminded itself that we are looking at matters afresh. We do that by taking into account all of the evidence in the hearing bundle and the oral evidence from all the witnesses, most importantly, Dr Abdollahi. We have applied the requirements in sections 3, 4 and 17 of the Act and Regulations 12 and 17. We have paid regard to the Enforcement Policy (February 2015) and the Enforcement Decision Tree documents (January 2017) which set out the principles applied by the Respondent in decisions of this kind. We have considered at all times the principle of proportionality, which we must consider, amongst other factors, pursuant to section 4 of the Act.

74. We have also borne in mind the Appellant's regulatory history, noting that he had periods of inconsistency, but they were quite some time ago. However, we took into account that the timescale for improvement has been approximately 16 months (to the end of August 2021, just before the appeal hearing). In this case, we have significant concerns that the service has not been able to demonstrate embedded improvements to such an extent that it

was found to have no breaches on the inspection of March 2021.

75. We did have concerns with Dr Abdollahi's evidence. On the one hand, he accepted the various concerns of the Respondent, but on the other, he wanted more time and support to make things right, including following whatever the Tribunal panel/the Respondent might direct by way of improvement. We concluded that Dr Abdollahi's understanding of the seriousness of the regulatory interventions in March 2020 and the steps to be undertaken from then onwards was and is limited. We have concluded that his ability to provide safe and effective care to patients is constrained by his level of knowledge and lack of detailed understanding of his regulatory requirements and responsibilities as a registered provider. This has not reassured us on risk of repetition if Dr Abdollahi were to continue as a registered provider.

76. We have considered carefully the decision of the Respondent from 7 January 2021. We have concluded, without hesitation, that at the time when the decision was made, it represented a proportionate response. However, our role does not end there, we are required to consider the developments since the point of the decision, which include the corrective efforts made by Dr Abdollahi since then, as well as the outcome of the further inspection from March 2021. The Tribunal has considered all of the material extremely carefully, applying the principle of proportionality, which requires us to examine the reasonableness of a response against the nature of the concerns that response must meet. We have concluded that the decision to cancel the registration of Dr Abdollahi to provide three regulated activities remains a proportionate decision which meets the requirements of section 4 of the Act.

Decision

The appeal is dismissed.

The Respondent's decision of 7 January 2021 to cancel the registration of Dr Abdollahi is confirmed.

Judge S Brownlee
Care Standards & Primary Health Lists Tribunal
First-tier Tribunal (Health, Education and Social Care)

Date issued: 08 October 2021