

**Fitness to Practise Panel
Dr David Patrick SOUTHALL**

29 September 2011

Determination in relation to Serious Professional Misconduct

Dr Southall

The Panel has considered your case in accordance with the General Medical Council Preliminary Proceedings Committee and Professional Conduct Committee (Procedure) Rules 1988.

The task for the Panel at this stage of the hearing has been first to determine whether, on the basis of the facts found proved, you have been guilty of serious professional misconduct. If the Panel finds that you have been guilty of serious professional misconduct, it is then required to consider what action, if any, to take in respect of that misconduct. The Panel's consideration has been limited to the matters relating to the letter that you wrote to Dr Dinwiddie on 22 March 1990 (the 'Dinwiddie letter') about Child H and the files you set up for the cases that you dealt with in your unit ('Special Cases (S/C) files') as they relate to Child D and Child H only.

The Panel has taken into account all the evidence it has heard and read throughout this hearing. It has referred to its determination on the facts previously found proved and its reasons for those findings, the GMC's publication 'Professional Conduct and Discipline: Fitness to Practise' (March 1989 edition) which was applicable at the time

of the events. Further, the Panel has had regard to the context and circumstances in which you were then working.

The Panel has considered the submissions made by Mr Tyson on behalf of the Complainants and Miss O'Rourke on your behalf. It paid due attention to the complexity of the case as a whole and the views of the medical experts. The Panel exercised its own judgment and came to its own conclusion.

The Panel accepted the advice of the Legal Assessor who stated that the Panel should judge your actions not with the wisdom of 13 to 22 years' hindsight and the advantage of modern approaches, but in the culture prevailing at the time of the events in respect of which findings have been made. He also advised that your actions must be judged in context.

The Panel noted that the period of time that has elapsed since the events occurred was not relevant at the facts stage but is relevant at this stage of the hearing.

The Legal Assessor reminded the Panel that serious professional misconduct is not defined in legislation. However, he referred to the relevant case law, drawing the Panel's attention to the judgments in Roylance v GMC (Privy Council, 1999), Dr Nandi v GMC [2004] EWHC 2317 (Admin) and GMC v Professor Sir Roy Meadow [2006] EWCA Civ 1390. The Legal Assessor quoted in particular from Roylance where it is stated:

“... It is not any professional misconduct which will qualify. The professional misconduct must be serious. ...”

The test that the Panel has applied is whether, when looking at all the facts that have been admitted and found proved, your conduct amounted to a serious falling below the standard which might be expected of a doctor practising in the same field of medicine in similar circumstances.

The Complainants did not adduce any oral evidence in relation to the seriousness of the facts found proved. Miss O'Rourke, on your behalf, called evidence from Dr Leonard Williams and Dr Margaret Crawford, consultant paediatricians, as expert witnesses, and several other consultant paediatricians. The Panel noted from the evidence given by some of these doctors that, at the time of the events, there were no formal rules, regulations or guidance in relation to copying medical correspondence or the keeping of files separate from main hospital medical records. It noted that Dr Williams and Dr Crawford gave their opinions on those matters from the perspective of their own experience and practice as consultant paediatricians.

The facts found proved

From 1982 you were a senior lecturer and subsequently also a consultant paediatrician based at the Royal Brompton Hospital, London. From 1992, you were Professor of Paediatrics at the University of Keele and also a consultant paediatrician at the North Staffordshire Hospital, Stoke on Trent.

The Dinwiddie letter

In March 1989 Child H was referred to you at the Royal Brompton Hospital by Dr Dinwiddie of Great Ormond Street Hospital for investigation and advice. Child H was admitted to the Royal Brompton Hospital, where his breathing was monitored, in September 1989 and again in March 1990.

On about 22 March 1990 Child H's parents informed you that they no longer wanted you to be involved in the management of Child H's care.

On 22 March 1990 you wrote to Dr Dinwiddie ('the Dinwiddie letter') stating that Child H's parents were not acting in Child H's best long term interests, you were suspicious of their motives and that you viewed Child H's long term prognosis with great concern.

You copied the letter addressed to Dr Dinwiddie to an unnamed consultant paediatrician at the Royal Gwent Hospital even though no one there was involved in Child H's care. You did not seek, nor obtain, Child H's parents' consent to the fact of involving a local paediatrician in Child H's care, or to any letter being sent to an unnamed local paediatrician, or to the Dinwiddie letter being sent to an unnamed local paediatrician. The Panel found that your actions were inappropriate and in breach of Child H's and his parents' confidentiality.

The Special Cases (S/C) files in relation to Child D and Child H

You created, or caused to be created, S/C files wherein certain original medical hospital records relating to these children were then placed by you or on your behalf. The cited medical records were not elsewhere in the children's hospital medical records.

The placing, or causing to be placed by you or on your behalf, of such cited original medical records in S/C files, damaged the integrity of the children's hospital medical records and caused any such item to be inaccessible to others involved in the medical care of the children at that time or in the future.

The Panel found that your actions were not in the best interests of the children concerned, inappropriate and an abuse of your professional position.

You treated Child H at the Royal Brompton Hospital and there created an S/C file for him. That S/C file contained original Royal Brompton Hospital medical records. You took, or caused to be taken, the S/C file relating to Child H away from the Royal Brompton Hospital and to the North Staffordshire Hospital where your unit was relocated in 1992. Given that Child H was not treated at the North Staffordshire Hospital, but only at the Royal Brompton Hospital, the Panel found that your action in transferring the S/C file for Child H was not in his best interests, was inappropriate and was an abuse of your professional position.

Determination in relation to serious professional misconduct

The Dinwiddie letter

The Panel noted that you believed that, in copying the letter to an unnamed consultant paediatrician, you were acting in the best interests of the child. You told the Panel that you wished to alert a consultant paediatrician at Child H's local hospital about his tracheostomy and your child protection concerns, in case he was taken to the Royal Gwent Hospital in an emergency. However, you acknowledged in evidence that it would have been better to have sent the copy letter to a named consultant.

The Panel also took account of the evidence of Dr Dinwiddie, to whom the letter was addressed. He told the Panel that, had he been in that position, he would have attempted to identify an individual because communication would have been better. However, he did not criticise your actions in relation to the letter on any other point.

The Panel had regard to the evidence of Dr Williams and Dr Crawford, as well as that of Professor David, the expert witness called on behalf of the Complainants at the facts stage.

Dr Williams stated in his evidence:

“I think he should have written this to a named paediatrician ... I think it would have been better to do so. ... I think it is useful to name somebody. It just makes them know that it is their job. They cannot pretend it is somebody else's job at that stage.”

However, Dr Williams also stated that he routinely sends letters containing sensitive information to unnamed clinicians and that virtually every hospital sends letters to “Child Health Departments” in child protection cases. Furthermore, he stated that letters that he receives from other doctors are rarely addressed to him. He did not suggest that the practice was different in 1990.

Dr Crawford stated in her report dated 16 December 2008 that she believed that:

“... the failure to name the paediatrician and the failure to contact the paediatrician were mistakes but to put them in context, they are minor mistakes.”

In his evidence at the facts stage, Professor David said:

“There is not a problem with a paediatrician sharing his concerns of a child protection nature with another paediatrician who might have contact with that child. One might go further than that and might say you would have a duty to do that.”

On the basis of Professor David’s evidence, the Panel stated in its reasons for its findings of fact that it was appropriate not to seek the consent of Mrs H when involving a local paediatrician.

The Panel accepts that the breach of confidentiality was justified by your child protection concerns about Child H and your professional duty in relation to his safety. In his oral evidence at this stage, Dr Dinwiddie supported that view.

The evidence indicates that you should have named a specific consultant paediatrician at the Royal Gwent Hospital when sending the copy of the Dinwiddie letter. You did not do so and the Panel found that to be unacceptable. However, in the light of the standards of practice which existed at the time, the Panel is satisfied that your actions, though inappropriate, amounted to an error of professional judgment which it does not regard as serious.

The Special Case files

In making its findings of fact, the Panel was upholding matters of principle as they related to the children in this case. It was affirming the importance of medical

practitioners' ensuring that medical records are accurate, complete and accessible to those with a need or a right to see them. In his report, Dr Williams noted that the principle of good record keeping was enshrined in medical practice even before it was first set out in the GMC's publication 'Good Medical Practice' in 1995.

In assessing the seriousness of the failings it had identified, the Panel carefully considered the specific circumstances applicable to the documents (listed in 'Appendix 1') forming the subject matter of the charge in relation to the S/C files of Child D and Child H. It bore in mind paragraph 201 of the Meadow judgment which states:

“... Whether it can properly be regarded as “serious” professional misconduct, however, must depend on the circumstances, including with what intention and/or knowledge and understanding he strayed ... how he came to do so, to what possible, foreseeable effect ...”

A factor that the Panel considered to be important was that, as stated by Dr Williams in his report, there was no evidence that your actions altered, or intended to alter, the clinical picture portrayed in the hospital notes.

In neither of the children's cases was the clinical picture in the hospital notes made erroneous or misleading. For example, although Mr Tyson suggested that certain information about Child D's allergies appeared only in one of the documents omitted from the main hospital medical records, in fact Child D's allergies were detailed adequately in the main hospital medical records. Furthermore, letters only in the S/C files and missing from the main hospital medical records were generally either copies of correspondence between other doctors or had been copied to other doctors. This meant that they were also to be found on other medical files. These matters were well set out by Dr Williams in section 7 of his report.

Dr Williams stated that there were good reasons for the S/C files when they were first set up in the 1980s. Giving an example he said:

“...It is necessary for research workers to maintain their own file of their research topics, whether the results are clinical or laboratory data. ...”

He also made the point that there was no guidance or protocols to be followed. The expert witnesses emphasised that the main problem arose from inadequate signposting to the existence of the S/C files, a point that the Panel made in the reasons that it gave for its findings of fact at stage one. The Panel heard evidence that many other practitioners have kept separate files in a wide variety of practices around the country which continue to this day.

The Panel accepted that you thought that you were acting in the children’s best interests in setting up the S/C files and further accepted that their existence made practical sense initially as you were undertaking research at a tertiary centre. However, your lack of a sign-posting or flagging system was a fault and the evidence indicates that, having created your special case files, you should have ensured that the material that they contained was appropriately accessible. The Panel noted the evidence that separate files have never been and should not be a substitute for main hospital medical records.

In his report Dr Williams expressed his opinion that, even though the documents set out in Appendix 1 were not very important, he saw no reason why they should not be in the medical records. He also stated that the correct default position is that all documents pertaining to an individual should be integrated into a single copy of the medical records relating to that patient. However, as already indicated, the Panel has accepted that by keeping the S/C files, you did not intend to conceal any documents that they contained. Furthermore, Dr Crawford stated in her report that any damage caused by the keeping of the separate records was minor.

In summing up at the end of his report, Dr Williams stated:

“...These letters should have been in the Stoke hospital records. I do not think this was a very serious wrong-doing that other members of the profession

would look upon with condemnation. If this matter had been brought to my attention in my position as lead clinician, I would have ensured that Dr Southall's system was updated to ensure the completeness of the medical records and better sign-posting. I would have asked for assistance in finding a better method of holding his special data. This would not have, I think, amounted to an internal disciplinary matter because I do not think it would have been thought to be that serious and because I think it would have been seen as a joint failure. ... I believe that I would have considered this to be a fault that needed to be resolved and not an error that needed disciplinary action..."

The Panel regarded this as highly relevant.

The Panel also noted Dr Crawford's letter published in 'The Lancet' on 3 January 2009 in which she concluded that:

".. achieving a single clinical record for a particular child in the UK is not straightforward and the all encompassing electronic record is still some years away."

The Panel accepts that your role with respect to Child H and Child D was in a tertiary referral unit that was located first at the Royal Brompton Hospital and then at North Staffordshire Hospital. As a consequence, your involvement with Child H and Child D was distinct from any clinical treatment they received at the hospitals where they received their main ongoing care. The Panel therefore accepts that it was reasonable for you to create S/C files in relation to those children. Whilst it also accepts that there was some justification for moving Child H's S/C file when your unit relocated to North Staffordshire Hospital the Panel is concerned that in doing so a number of documents that should have been in the main hospital medical files were moved from that hospital. In his report, Dr Williams said:

"... Anything that was taken should be a copy of a document and should not alter the clinical impression of the notes."

However, the Panel has accepted the evidence from the expert witnesses that your basic intentions were good and that no great damage was caused to the integrity of the hospital medical records.

The Panel has therefore concluded that your actions in relation to the S/C files were not serious.

Taking all the facts found proved together and having regard to all the evidence presented, the Panel has concluded that you are not guilty of serious professional misconduct.

That concludes your case.