PUBLIC RECORD

Dr Demanya has appealed decisions of this Tribunal. His registration remains suspended while his appeal is considered as a result of the immediate order imposed by the Tribunal.

Dates: 11/04/2023 - 02/05/2023
05/12/2023 - 06/12/2023

Medical Practitioner's name: Dr Allen DEMANYA

GMC reference number: 6057229

Primary medical qualification: MB ChB 1991 University of Science and Technology

Type of case	Outcome on facts	Outcome on impairment
New - Misconduct	Facts relevant to impairment found proved	Impaired

Summary of outcome

Erasure
Immediate order imposed

Tribunal:

Legally Qualified Chair	Mr Gerry Wareham
Lay Tribunal Member:	Mr John Ennis
Medical Tribunal Member:	Dr Vivek Sen (11 April to 2 May)
Medical Tribunal Member:	Dr Nagarajah Theva (5 to 6 December)

Tribunal Clerk:	Mr Sewa Singh Mr Matt O'Reilly (28 April) Mr Joel Taylor-Garratt (5 to 6 December)

Attendance and Representation:

Medical Practitioner:	Present, represented
Medical Practitioner's Representative:	Mr Christopher Mellor, Counsel, instructed by Medical Protection
GMC Representative:	Mr Charles Garside, KC

Attendance of Press / Public

In accordance with Rule 41 of the General Medical Council (Fitness to Practise) Rules 2004 the hearing was held in public.

Overarching Objective

Throughout the decision making process the tribunal has borne in mind the statutory overarching objective as set out in s1 Medical Act 1983 (the 1983 Act) to protect, promote and maintain the health, safety and well-being of the public, to promote and maintain public confidence in the medical profession, and to promote and maintain proper professional standards and conduct for members of that profession.

Determination on Facts - 27/04/2023

Overarching Objective

1. Throughout the decision-making process the Tribunal has borne in mind the statutory overarching objective as set out in s1 Medical Act 1983 (the Act) to protect, promote and maintain the health, safety and well-being of the public, to promote and maintain public confidence in the medical profession, and to promote and maintain proper professional standards and conduct for members of that profession.

Background

2. Dr Demanya qualified in 1992 at the Kwame Nkrumah University of Science and Technology in Ghana. He spent several years in various training positions at hospitals in Ghana before moving to the UK in 2003 where he worked at several hospitals. In 2004, Dr Demanya commenced a Senior House Officer (SHO) role at Hillingdon Hospital in London, part of the Hillingdon Hospitals NHS Foundation Trust. In February 2005, he was appointed as a Specialty Doctor at middle grade. Whilst working at the Hospital, Dr Demanya undertook locum work at various other hospitals. In 2021, he completed his FRCEM exams and on 1 March 2022 was offered a locum consultant position at the Hospital, a long-term locum role which he has held since.

3. At the time of the alleged events, Dr Demanya was working as a locum middle grade doctor in the Emergency Department ('ED') at the Royal Glamorgan Hospital ('RGH').

4. The Allegation that gave rise to this hearing is set out in full below, but in brief it is alleged that Dr Demanya, while involved in the care of Patient A at the RGH on 26 February 2019, failed to provide proper care and treatment in that he failed to make a specific diagnosis of severe infection or to take particular and specified steps to treat such an infection.

5. It is also alleged that Dr Demanya retrospectively and dishonestly added matters to Patient A's treatment plan and prescription chart within her medical records. This included adding to his treatment plan antibiotics on her prescription chart, and instructions to catheterise and monitor input/output. It is also alleged he later crossed out the antibiotics prescription without a valid reason or record as to why he had done so. Further, it is alleged that on 25 February 2020, Dr Demanya dishonestly made a false representation to the Coroner in respect of these matters.

Background

6. On 26 February 2019, Patient A, a female aged 75, was brought to RGH via ambulance. She arrived at the Accident and Emergency ('A&E') department at 01:51 presenting with diarrhoea, pyrexia, tachycardia and low blood pressure. She was triaged at 02:11 where it was recorded that she had diarrhoea, a high temperature (38.5), increased heart rate (114), and low blood pressure (99/63). The nurse who triaged Patient A wrote 'possible sepsis' on her triage notes. Patient A was assessed as an 'Orange' category patient (to be seen by a doctor within ten minutes) and placed in a cubicle in the A&E department to reduce the risk of infection to other patients.

7. Dr Demanya examined Patient A at 03:00 and put in place a treatment plan and prescribed medication. The precise extent of the plan and prescriptions are matters in dispute and considered in detail below. At or before 04:00 Patient A fell out of her bed. She was found on the floor in the cubicle by Nurse C and was helped back on to the trolley. Dr Demanya examined Patient A at 05:00. During the night shift, Patient A was treated by Dr Demanya and other members of the A&E staff at various times. At around 07:00 Dr D arrived having been alerted by bleeper and telephone call. He expressed concern regarding the condition of Patient A, and Dr E (consultant in acute medicine) attended to undertake her post-take ward round.

8. Patient A died in the hospital's A&E department on 27 February 2019 at 00:40. An inquest into Patient A's death took place on 25-26 February 2020.

The Outcome of Applications Made during the Facts Stage

9. The Tribunal granted two applications made by Mr Charles Garside KC, Counsel for the GMC, pursuant to Rule 34(13) of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended ('the Rules'), to allow Nurse B and Dr D to give evidence via video-link. The applications were not contested by Dr Demanya's Counsel, Mr Christopher Mellor. The Tribunal's reasons are set out in Annexes A and C.

10. The Tribunal granted an application made by Mr Mellor, pursuant to Rule 34(13) of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended ('the Rules'), to allow Dr H and Dr I to give evidence via video-link. The applications were not contested by the GMC. The Tribunal's reasons are set out in Annex D.

11. In private session, the Tribunal granted an application made by the GMC on behalf of Mr Mellor, for an adjournment of proceedings until 17 April 2023. The Tribunal's reasons are set out in Annex B.

The Allegation and the Doctor's Response

12. That being registered under the Medical Act 1983 (as amended):

1. On 26 February 2019 you were involved in the care of Patient A at Royal Glamorgan Hospital and you:

a. failed to:

i. make a specific diagnosis of severe infection;
To be determined

ii. consider a differential diagnosis of intra-abdominal infection or acute abdomen;
To be determined

iii. prescribe antibiotics to Patient A either:

1. at all; or
To be determined

2. within an adequate time period;
To be determined

iv. include as part of your treatment plan for Patient A:

1. referral to the surgical team;
To be determined (Admitted as a matter of fact only)

2. catheterisation and/or urinary output monitoring;
To be determined

v. escalate the seriousness of Patient A's condition to either the:

1. medical registrar on call; or
Admitted and found proved

2. emergency medicine consultant;
To be determined (Admitted as a matter of fact only)

b. retrospectively added:

i. antibiotics to Patient A's prescription chart;
To be determined

ii. 'catheterise…intake/output monitoring' to your treatment plan in Patient A's medical record;
To be determined

c. crossed out the antibiotic prescriptions in Patient A's prescription chart without a valid reason for doing so;
To be determined

d. failed to record:

i. why you had crossed out the antibiotic prescriptions in Patient A's prescription chart;
To be determined

ii. that 'catheterise…intake/output monitoring' had been retrospectively added to your treatment plan in Patient A's medical record.
To be determined

2. On 25 February 2020 you made a false representation to the Coroner in that you stated:

a. you prescribed antibiotics to Patient A as part of your treatment plan, or words to that effect;
To be determined (Admitted as a matter of fact only)

b. that catheterisation and/or urinary output monitoring was part of your treatment plan, or words to that effect.
To be determined

3. You:

a. added the entries mentioned in paragraph 1b to give the false impression that they had been part of your treatment plan;
To be determined

b. knew, at the time of your actions set out in paragraph 1b and paragraph 2, that:

i. antibiotics had not been part of your treatment plan;
To be determined

ii. catheterisation and urinary output monitoring had not been part of your treatment plan.
To be determined

4. Your action described at paragraph:

a. 1bi was dishonest by reason of paragraph 3a and 3bi;
To be determined

b. 1bii was dishonest by reason of paragraph 3a and 3bii;
To be determined

c. 2a was dishonest by reason of paragraph 3bi;
To be determined

d. 2b was dishonest by reason of paragraph 3bii.
To be determined

And that by reason of the matters set out above your fitness to practise is impaired because of your misconduct.
To be determined

The Admitted Facts

13. At the outset of these proceedings, through his Counsel, Mr Mellor, Dr Demanya admitted paragraph 1(a)(v)(i) of the Allegation, as set out above. This was, in accordance with Rule 17(2)(d) of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended ('the Rules'). The Tribunal announced the paragraph as admitted and found proved, in accordance with Rule 17(2)(e) of the Rules. The admissions are reflected in the Allegation as set out above. Dr Demanya also admitted, as a matter of fact only, paragraphs 1(a)(iv)(i) and 1(a)(v)(2) of the Allegation.

The Facts to be Determined

14. In light of the above, the Tribunal had to determine the disputed elements of the Allegation, as set out above.

Witness Evidence

15. The Tribunal received oral evidence on behalf of the GMC from the following witnesses, together with their witness statements and exhibits:

- Nurse B, witness statement dated 27 October 2021;
- Nurse C, witness statement dated 18 January 2022;
- Dr D, witness statements dated 17 December 2021 and 21 March 2023;
- Dr E, witness statements dated 17 February 2022 and 16 March 2023.

16. The Tribunal also received, on behalf of the GMC, oral evidence from Dr F, expert witness, together with his reports dated 13 March 2022 and 1 March 2023.

17. The Tribunal received the witness statement of Nurse G, dated 1 December 2021. Nurse G was not called to give evidence.

18. The Tribunal received oral evidence on behalf of Dr Demanya from Dr H and Dr I.

19. Dr Demanya provided witness statements dated 16 February 2023 and 16 March 2023. He also gave oral evidence at the hearing.

Documentary Evidence

20. The Tribunal had regard to the documentary evidence provided by both parties. This included but was not limited to:

- Patient A's Triage note;
- Dr Demanya's Casualty Card ('Cas Card') medical record of Patient A;
- Patient A's other medical records;
- Statements provided by clinical staff involved in Patient A's care to the coroner;
- A transcript of relevant evidence from the coroner's inquest;
- Testimonial letters from Dr Demanya's clinical colleagues;
- Dr Demanya's Curriculum Vitae (CV).

The Tribunal's Approach

21. The Tribunal accepted the Legally Qualified Chair's advice as follows:

> '1. *In reaching its decision on facts, the Tribunal bears in mind that the burden of proof rests on the GMC and it is for the GMC to prove the Allegation. The standard of proof is that applicable to civil proceedings, namely the balance of probabilities, i.e., whether it is more likely than not that the events occurred.*

2. In assessing a witness's credibility, the Tribunal reminds itself that it should not assess witness credibility exclusively on the demeanour of the witness when giving their evidence, but their veracity should be tested by reference to objective facts proved independently in their evidence, in particular by reference to the documents in the case. The Tribunal should make a rounded assessment of a witness's reliability, rather than approaching their reliability in respect of each charge in isolation from the others: R (on the application of Dutta) v GMC [2020] EWHC 1974 (Admin).

3 It is open to the Tribunal not to rule out the whole of a witness's evidence based on credibility; credibility could be divisible: Khan v The General Medical Council [2021] EWHC 374 (Admin).

4 The Tribunal note that, when considering the evidence of any witness in this case, it should also bear in mind the extent to which the passage of time may have affected the memory of a witness. The Tribunal would be aware from its own experience that memories can fade with the passage of time, and that recollections may change, or may become confused, as to what did or did not happen at a particular time. The Tribunal should make due allowance for the way in which the passage of time may have affected the recollections of any of the witnesses.

5. In relation to witnesses generally, the Tribunal bear in mind that an honest witness could be mistaken, and a mistaken witness was not necessarily wrong about every fact.

6. As to individual pieces of evidence, the Tribunal is entitled to draw proper inferences - to come to common sense conclusions based upon the evidence which it accepted as reliable; but it must not speculate. Similarly, the Tribunal should not speculate about what other evidence there might have been. The Tribunal should only draw an inference if it could safely exclude other possibilities: Soni v GMC (2015) EWAC 0364 Admin.

7. The Tribunal has regard to the Supreme Court judgment in the case of Ivey v Genting Casinos (UK) Limited [2017] UKSC 67, in which Lord Hughes set out the correct test for dishonesty, which is as follows:

> *'When dishonesty is in question the fact-finding tribunal must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts. The reasonableness or otherwise of his belief is a matter of evidence (often in practice determinative) going to whether he held the belief, but it is not an additional requirement that his belief must be reasonable; the question is whether it is genuinely held. When once his actual state of mind as to knowledge or belief as to facts is established, the question whether his conduct was honest or dishonest is to be determined by the fact-finder by applying the (objective) standards of ordinary decent people. There is no requirement that the defendant must appreciate that what he has done is, by those standards, dishonest.'*

8. Expert evidence is permitted to provide the Tribunal with information and opinion, which is within the witness' expertise, but which is likely to be, or may be outside our experience and knowledge. It is important that the Tribunal should see it in its proper perspective, which is that it is part of the evidence as a whole to assist in regard to any particular aspect of the evidence to which it relates and to come to any conclusions on the basis of our own observations. The Tribunal should consider the experts' evidence and attach such weight to it as considered appropriate in being able to make a determination on the outstanding denied factual allegations. The Tribunal should bear in mind that if, having given the matter careful consideration, they determine not to accept the evidence of an expert, they do not have to accept it. Indeed, the Tribunal do not have to accept even any unchallenged areas of evidence of an expert, but it is for them to decide whose evidence, and whose opinions to accept, if any. However, if the Tribunal do not accept the expert evidence, then they should give reasons within the record of the decision.

9. Doctor Demanya is of good character which must be taken into account by the Tribunal when assessing his credibility and the likelihood of him having done what has been alleged. His good character is not a defence to the Allegation, it is simply one factor to take into account when considering all of the evidence in the round. The weight to assign Dr Demanya's good character is a matter for the Tribunal to determine.'

The Tribunal's Analysis of the Evidence and Findings

22. In respect of the outstanding paragraphs of the Allegation, the Tribunal considered them separately and evaluated all the evidence in relation to each element to make its findings on the facts.

Paragraph 1(a)(i)

1. On 26 February 2019 you were involved in the care of Patient A at Royal Glamorgan Hospital and you:

    a. failed to:

        i. make a specific diagnosis of severe infection;

23. The Tribunal had particular regard to Patient A's medical records and the entries made by Dr Demanya when he assessed Patient A at 03:00 on 26 February 2019. The medical record in relation to Patient A, the 'Cas Card', exhibit MA4, was central to the evidence as to what diagnosis was made by Doctor Demanya, what treatment was ordered and administered and when this occurred. On this treatment plan was written:

'Generalised Tenderness
Guarding
No rebound Tenderness

Imp: Gastroenteritis *Catheterise*
Analgesia *Intake/Output Monitoring*
IV Fluids
Bloods + Cultures
Urine Dip
AXR
Erect CXR
Stool for Culture'

24. In his witness statement, dated 16 February 2023, Dr Demanya stated at paragraphs 22, 25 and 26:

'22. As part of my assessment, which I performed whilst Nurse C was in and out of the cubicle, I reviewed Patient A's history, most of which I took from the ambulance records which were available to me at the time; as well as from Nurse G's brief triage notes, which, as set out above, included reference to possible sepsis, pyrexia, tachycardia and low BP. Patient A's son was also present in the cubicle and able to help with the history and Patient A was able to give a limited history herself.'

and

'25. The ambulance records stated that Patient A had had diarrhoea since that morning, that her GP had advised stopping the antibiotics she had been taking for a chest infection and commencing co-codamol and oral fluids. The ambulance records also listed Patient A's co-morbidities, routine medications and some social history.

26. As part of my own history taking, as set out above, I recorded five episodes of diarrhoea with runny stools, generalised abdominal pain, and no vomiting. I noted that Patient A's son had spoken with Patient A's GP, who had advised discontinuing the antibiotics she had been taking (Amoxicillin) for the chest infection.'

25. It was Dr Demanya's evidence that he had suspected sepsis from the point of this initial examination and had diagnosed gastroenteritis as the cause of it.

26. In his report dated 13 March 2022, Dr F stated:

'I note that Dr Demanya made a provisional diagnosis of gastro-enteritis. This is a reasonable diagnosis given that Patient A presented with a history of diarrhoea, abdominal pain and fever. Although there was no history of vomiting, this would still be in keeping with a diagnosis of gastroenteritis.'

and further:

'The failure to make a specific diagnosis of sepsis and to consider a differential diagnosis of other intra-abdominal infective or inflammatory conditions falls below the standard expected but not seriously. Not seriously because Dr Demanya made a

reasonable diagnosis of gastroenteritis, the treatment and management plan with fluids and antibiotics as prescribed by Dr Demanya were reasonable and appropriate for gastro enteritis as well as for sepsis arising from an intra-abdominal cause.'

27. During his evidence to the Tribunal, Dr F confirmed that gastroenteritis was an infection of the abdomen which can be serious and can lead to complications, including sepsis, but can also be mild.

28. The Tribunal noted that although Dr Demanya recorded '*Analgesia*' in his treatment plan, and also prescribed paracetamol on the next page of the Cas Card, there is neither mention of 'sepsis', nor antibiotics for the treatment of sepsis, within this treatment plan.

29. The Tribunal had regard to the treatment plan later devised by Dr E for Patient A. In this the antibiotics prescribed by her were clearly stated:

'Plan	*1*	*IVI (Switch to N.Saline given K+) & IV bicarb*
	2	*STAT IV Taz and metronidazole*
	3	*T&O r/v*
	4	*Surgical r/v (I've spoken to surg cons)*
	5	*Insulin & dextrose*
	6	*CSU please'*

30. The Tribunal also considered very carefully the evidence of Dr D in this regard. He was very specific as to what was conveyed to him as regards Patient's A condition. Both he and Dr Demanya agree the word '*sepsis*' was not used. The Tribunal accepted the evidence of Dr F and others that the severity of her condition could be conveyed without the express use of that term, but that would require the provision of specific information.

31. Dr Demanya's account is that having conveyed all the relevant information to him, Dr D expressed surprise he had prescribed antibiotics. The Tribunal found it particularly unlikely that an experienced doctor would respond in such a way if made aware of the information Dr Demanya says he relayed, which he states clearly indicated sepsis even if he did not utilise that term.

32. Dr D states that Dr Demanya referred to abdominal pain and acute kidney injury. He states he was carrying x-ray forms. Dr D formed the view that Dr Demanya believed that bowel obstruction or perforation was suspected and states he told Dr Demanya to contact him again if the x-rays ruled out surgical intervention. He states that he perceived the purpose of the discussion to be a possible referral to his team, and that he suspected the request would be revisited if the x-rays ruled out a surgical approach. He was insistent in his evidence that he was never made aware of the gravity of Patient A's condition and would have had no cause to decline to assist if he was. He also stated that if he was aware, he would have alerted his seniors as per local protocol.

33. On the basis of all the evidence before it, and in the absence of any clear or objective evidence that Dr Demanya had indeed diagnosed sepsis or severe infection, the Tribunal

concluded that on 26 February 2019, Dr Demanya failed to make a specific diagnosis of severe infection. It therefore found paragraph 1a(i) of the Allegation proved.

Paragraph 1(a)(ii)

1. On 26 February 2019 you were involved in the care of Patient A at Royal Glamorgan Hospital and you:

a. failed to:

ii. consider a differential diagnosis of intra-abdominal infection or acute abdomen;

34. The Tribunal again had regard to Patient A's medical records and the entries made by Dr Demanya when he assessed Patient A at 03:00 on 26 February 2019. In the Cas Card in relation to Patient A's treatment plan, it was stated:

'Generalised Tenderness
Guarding
No rebound Tenderness

Gastroenteritis
Analgesia
IV Fluids
Bloods + Cultures
Urine Dip
AXR
Erect CXR
Stool for Culture'

Catheterise
Intake/Output Monitoring

35. The Tribunal considered Dr F's report, dated 13 March 2022, in which he stated:

'I note that "sepsis" was not specifically mentioned as a differential diagnosis. Patient A presented with fever, tachycardia (fast heart rate), low blood pressure on a background of diarrhoea. These clinical features are in keeping with a possible diagnosis of sepsis. However, it is important to note that the development of sepsis is usually the result of infection or inflammation in the relevant anatomical regions of the body; this could be the chest, abdomen, pelvis and soft tissues. Therefore "gastroenteritis" being an infection or inflammation within the gastrointestinal tract, can result in sepsis. The clinical information available to Dr Demanya was sufficient to make a diagnosis of sepsis which could have been secondary to the gastroenteritis.'

36. He goes on to state:

'The failure to make a specific diagnosis of sepsis and to consider a differential diagnosis of other intra-abdominal infective or inflammatory conditions falls below the

standard expected but not seriously. Not seriously because Dr Demanya made a reasonable diagnosis of gastroenteritis, the treatment and management plan with fluids and antibiotics as prescribed by Dr Demanya were reasonable and appropriate for gastro enteritis as well as for sepsis arising from an intra-abdominal cause.'

37. On the basis of the investigations instigated by Dr Demanya in his treatment plan, the Tribunal was satisfied that Dr Demanya had considered a differential diagnosis of intra-abdominal infection or acute abdomen. The investigations he had ordered were indicative of his thinking along the lines of a surgical pathology. The Tribunal therefore found paragraph 1(a)(ii) of the Allegation not proved.

<u>Paragraph 1(a)(iii)</u>

1. On 26 February 2019 you were involved in the care of Patient A at Royal Glamorgan Hospital and you:

a. failed to:

iii. prescribe antibiotics to Patient A either:

1. at all; or

2. within an adequate time period;

38. The Tribunal considered paragraphs 1(a)(iii)(1) and (2) together.

39. In his statement for the coroner and in evidence under oath at the inquest Dr Demanya maintained explicitly that he prescribed antibiotics after his initial assessment of Patient A at 03:00. This was at the same time that he prescribed intravenous fluids and paracetamol.

40. At the inquest, and before this Tribunal, Nurse B's stated that when she administered the paracetamol there was no prescription for antibiotics written up and outstanding. She was clear that had there been, she would have administered it. She signed the prescription on the Cas Card to show she administered the paracetamol at 03:37, this is witnessed by a colleague.

41. In his statement prepared for these proceedings, and in his evidence to the Tribunal, Dr Demanya stated that following his evidence at the Inquest he remembered that it was in fact after Nurse B administered the paracetamol that he first wrote up the prescription for antibiotics. This was done after he saw the blood results at around 03:40.

42. The Tribunal heard from Dr Demanya that it was on later reflection as he recalled his conversation with Dr D, and in particular the discussion he claims they had regarding antibiotics, that his memory was 'jogged'. In defending his prescription of antibiotics

to Dr D he invoked the blood results and realises now they would not have been available at the time he first stated he prescribed, so it must have been later. He now remembers it was in fact when he saw those results that he did add the antibiotic prescription to the Cas Card.

43. The Tribunal noted:

- Dr D does not accept that this discussion took place as stated, and claims that it is inherently illogical that he would challenge or question a prescription for antibiotics if given the information Dr Demanya claims;
- The medical evidence is consistent that whilst the blood results supported or 'bolstered' a decision to prescribe antibiotics, it was not necessary or clinically prudent to await those results if sepsis was suspected;
- It is convenient for Dr Demanya to be able to explain away the fact that Nurse B stated at the inquest there was no prescription for antibiotics at 03:37;
- It would be surprising in the extreme if Dr Demanya was so mistaken about something so central to a matter under serious investigation by the Trust and the Coroner. The Tribunal noted he stated that he had only limited access to the notes, however he travelled from London to Glamorgan specifically to write the statement, has provided no evidence he was not granted access to any documents which he requested or was under undue or unfair time pressures, and he was clearly aware of the importance of what he was stating.

44. As regards his claim to have prescribed at around 03:40 Dr Demanya stated at paragraphs 38 and 39 of his statement that when he saw the Full Blood Count (FBC) results they

'*were in keeping with an infective cause of Patient A's abnormal observations, making the diagnosis of sepsis even more certain. I did not make a record of having reviewed the FBC results and I entirely accept that I should have recorded having reviewed them and what my findings were.*

In any event, having reviewed the FBC results and printed them off at 03.42, ***I then subsequently returned to the cubicle and added prescriptions for two IV antibiotics (being 1g of Amoxicillin and 500mg of Metronidazole)*** *to treat the sepsis, as fourth and fifth entries on the drug chart.'* **(emphasis added by the Tribunal)**

45. In her witness statement, dated 18 January 2022, Nurse C stated at paragraphs 15 and 19:

'15. ***Between 3.30am and 4.00am****, I went on my break. At approximately 4.00am on return from my break, I spoke to Nurse B who told me she had connected the IV paracetamol to Patient A.'* **(emphasis added by the Tribunal)**

'19. The IV paracetamol had finished before Patient A went for her x-ray. ***At approximately 5.50am*** *I mentioned to Dr Demanya that Patient A's blood pressure was still very low. I said to Dr Demanya, the previous IV saline bag is finished I asked can you prescribe another bag of Iv saline I signed the prescription chart and Nurse B co-signed.* ***There was no IV antibiotics on the prescription chart*** *at this stage. I then connected a new IV saline to Patient A.'* **(emphasis added by the Tribunal)**

46. In her witness statement, dated 27 October 2021, Nurse B stated at paragraph 27:

*'27. Dr Demanya was at the nursing station writing notes on the pages in the middle of the triage note. He stopped writing so I could sign the medication page to say I had given the patient paracetamol. The medication page is the back page of the triage note. On the medication page I saw 'paracetamol' and 'saline'****. I definitely didn't see 'antibiotics' written on the form at this time*** *as I would have offered to get them because Nurse C wouldn't have been able to get them out of the cupboards.'* **(emphasis added by the Tribunal)**

47. In his report, which he confirmed in his oral evidence to the Tribunal, Dr F stated:

'I would have expected Dr Demanya to have prescribed the antibiotics at the same time as the Paracetamol and saline at approx. 3:30am. It is certainly desirable to prescribe the antibiotics within one hour of assessment which would be by 04:00am. However, in my opinion, some delay in antibiotic administration (say up to 3 hours) would be acceptable.'

48. Dealing firstly with whether Dr Demanya prescribed antibiotics to Patient A '*within an adequate time period'*, the Tribunal considered the evidence and actions of Nurse C and Nurse B. It is not disputed that Dr Demanya prescribed i.v. saline and i.v. paracetamol following his initial examination of Patient A. The evidence before the Tribunal established that the instruction to administer these were acted upon in a very timely manner. Indeed, in cross examination Dr Demanya accepted that it would have been around 03:20 that he completed the prescription for paracetamol after his examination; the medication was administered at 03:37. (The Tribunal notes that the second bag of Saline was not administered until after 05:50, when Nurse C states she informed Dr Demanya that the first bag had finished.)

49. In relation to the antibiotics, the Tribunal considered that if Dr Demanya had prescribed antibiotics to Patient A at the time he now claims, it could identify no reason why this instruction would not have been acted upon with similar diligence as with the Paracetamol; particularly as any trained nurse would have recognised its importance.

50. It was clear from the evidence before the Tribunal that at as late as 05:50 when the second litre of i.v. fluids was commenced, no antibiotics had been administered. Dr Demanya states *"I am unable to explain why further i.v. fluids were administered at this point, but not antibiotics. I seem to recall that the i.v. fluids were stored separately to the antibiotics, and I therefore wonder if it was because access to the antibiotics was more restricted.'*

51. Dr Demanya is thereby suggesting that Nurse C, who would not have had direct access to the antibiotics, was or may have been aware of the prescription but failed to act. The Tribunal bore in mind the concerns expressed by the Doctor's counsel regarding Nurse C's evidence, her record keeping and the accuracy of some statements she makes. The Tribunal noted this and shared some of the concerns. However, it was of the view that whilst her system of recording was far from ideal, it should be noted she was not aware she was compiling them for legal proceedings. Her actions in creating a new note from the old and disposing of the first, ill-advised as they may have been, were not covert in that she told Dr E what she was doing. The material inaccuracies were seen by the Tribunal as markers as to the level of reliance that could be placed on her regarding detail, but not of themselves indicators of dishonesty. The Tribunal therefore bore all this in mind when considering her evidence and sought corroboration where possible.

52. The Tribunal noted that Nurse C, as an agency nurse, would need permission for access to any drugs she wanted to administer on every shift, for every patient. It seemed an unlikely bar to her performing her duty. It was also noted that Nurse B was nearby and had herself administered the paracetamol, within minutes of the prescription being made.

53. On consideration of all the evidence the Tribunal determined it was more likely that Dr Demanya had not prescribed the antibiotics by 05:50, almost three hours after his initial assessment of Patient A. It therefore found paragraph 1(a)(iii)(2) of the Allegation proved.

54. It was clear that at some point after 05:50, and before it was crossed out, Dr Demanya wrote a prescription for antibiotics. The Tribunal could find no evidence to determine when this happened or for how long the prescription stood. In the absence of such evidence, the Tribunal determined that the GMC had not discharged its burden of proof in relation to paragraph 1(a)(iii)(1). It therefore found paragraph 1(a)(iii)(1) of the Allegation not proved.

Paragraph 1 (a)(iv) 1

1. On 26 February 2019 you were involved in the care of Patient A at Royal Glamorgan Hospital and you:

a. failed to:

iv. include as part of your treatment plan for Patient A:

1. referral to the surgical team;

(Admitted as a matter of fact only)

55. Dr Demanya has admitted this particular of the Allegation as a matter of fact.

56. In his statement at paragraphs 85 and 86, dated 16 February 2023, Dr Demanya stated:

'85. My treatment plan included abdominal x-ray to exclude possible differential diagnoses of bowel obstruction and perforation (i.e. a surgical cause); and I referred to the General Medicine team given Patient A was acutely unwell and needed to be admitted.

86. As set out above, referral was delayed by what I perceived as a reluctance for Patient A to be accepted by Dr D and the referral was only accepted once the x-ray report (which ultimately D a bowel obstruction and/or perforation) was received. There was also, unfortunately, some delay in the x-ray report being received; however, when I initially spoke to Dr D, I thought that Patient A would be receiving the treatment I had prescribed, and I considered it would be acceptable to await the x-ray results.'

57. The Tribunal had regard to Dr D's evidence that he was of the view that Dr Demanya was considering referral to the surgical team if the x-rays indicated such was appropriate. He stated that he may have arranged a '*consult*' if he had care of Patient A, but accepted that her condition needed to be stabilised and key issues of immediate concern addressed first.

58. Dr F in his report, dated 13 March 2022, stated:

'…. I note that Dr A in his witness statement and the Coroner's Court transcript stated that Dr Demanya approached him at 0330 hours for advice about a patient with abdominal pain and AKI (acute kidney injury). He stated that he indicated to Dr Demanya that he will be happy to review the patient after a surgical emergency had been ruled out. He stated that he indicated that if the xray does not suggest a surgical cause for the abdominal pain then he would accept the patient. If this version of events from Dr A were accepted, then this would be appropriate. This because Patient A required emergency treatment with fluids and antibiotics prior to referral to the relevant specialty team. This management or care plan would fall within Dr Demanya's competency to provide.

It is also my opinion that Dr Demanya should have referred Patient A to the surgical team on call. This is because Patient A presented with abdominal pain and tenderness with guarding.

These findings would be in keeping with a diagnosis of an "acute abdomen" arising from a possible intraabdominal condition or infection such as abscess, diverticulitis, colitis or ischaemic bowel.

Another reasonable course of action was for Dr Demanya to refer for a joint management by both the medical and surgical teams on call.

The failure to refer Patient A to the surgical team on call falls below the standard expected but not seriously. Not seriously because the initial management and treatment plan with fluids and antibiotics as prescribed Dr Demanya were appropriate.'

59. The Tribunal noted Dr Demanya's treatment plan for Patient A. It also took into account that Dr Demanya made contact with Dr D, who he thought was the medical registrar. Further, Dr Demanya took Patient A's x-ray request card to the radiology department. In the Tribunal's view, this was indicative that Dr Demanya had considered in his treatment plan for Patient A referral to the surgical team. The Tribunal therefore found that although it was established as a matter of fact there had been no referral, this was not a failure of care and that therefore paragraph 1(a)(iv)(1) of the Allegation was not proved.

<u>Paragraph 1 (a)(iv) 2</u>

1. On 26 February 2019 you were involved in the care of Patient A at Royal Glamorgan Hospital and you:

a. failed to:

iv. include as part of your treatment plan for Patient A:

2. catheterisation and/or urinary output monitoring;

60. In his statement, dated 16 February 2023, Dr Demanya stated at paragraph 88:

'88. I included catheterisation and urinary output monitoring in my treatment plan. This was recorded at my 03:00 assessment of Patient A; and I chased the nurses several times when I realised Patient A had not been catheterised.'

61. During his oral evidence to the Tribunal, Dr Demanya maintained this account. He told the Tribunal that he wrote the treatment plan for Patient A at around 03:15 after he assessed her at 03:00, and that he included in it that she should be catheterised. Dr Demanya added that he asked the nursing staff on several occasions throughout the shift to catheterise Patient A.

62. The Tribunal had regard to Dr D's statement, dated 17 December 2021, in relation to his second conversation with Dr Demanya at 06:30. At paragraphs 17 and 18 he stated that he asked whether the patient was passing urine and '*Dr Demanya was unsure*'. He said that he then suggested a catheter and that Dr Demanya replied '*OK, we can arrange that*'.

63. Dr D was cross examined as regards this conversation, and in particular any assumption he may have formed as a result. He accepted that Dr Demanya may have said *'it will be done'*, but maintained under challenge that he formed a clear impression from the exchange that it was a new plan.

64. Nurse C is adamant she was never asked by Dr Demanya to catheterise Patient A. In paragraph 23 of her statement, she stated:

'23. Around this time perhaps at 7.00am, while Dr D (whom I recall

from the Inquest) came and reviewed the patient and asked me had the patient passed urine or had a bladder scan. I said no she had not passed urine, but had watery stool twice to my knowledge. Dr D then told me she needs to be catheterised. I asked one of the night staff to please get me a catheterisation kit while I was still trying to cannulate. The nurse said I shouldn't worry, the morning team are here. The only person that asked me to catheterise Patient A was Dr D.'

65. The Tribunal took into account Dr Demanya examined Patient A after her fall. In his evidence to the Tribunal, Dr Demanya said that he performed a '*top to toe'* examination of Patient A at 05:00, following her fall. However, either he did not notice that a catheter had not been fitted as he had requested or took no effective action as a result. This would have been nearly two hours after he had first requested it be done. The Tribunal considered it would have been obvious to Dr Demanya that a catheter had not been fitted. It appeared to the Tribunal highly unlikely that if catheterisation was an integral part of Dr Demanya's initial treatment plan he would have taken no decisive action at this time. There is also no evidence that, having ordered monitoring as he claims, he ever inquired as to Patient A's intake/output monitoring data. It is clear that a catheter was only fitted after 06:30 after Dr D had inquired whether Patient A had passed urine.

66. In the circumstances, the Tribunal determined, on the balance of probabilities, that Dr Demanya did not include catheterisation as part of his treatment plan for Patient A and therefore found paragraph 1(a)(iv)(2) of the Allegation proved.

Paragraph 1(a)(v) 1 and 2

1. On 26 February 2019 you were involved in the care of Patient A at Royal Glamorgan Hospital and you:

a. failed to:

v. escalate the seriousness of Patient A's condition to either the:

1. medical registrar on call; or

Admitted and found proved

2. emergency medicine consultant;

Admitted as a matter of fact only

67. The Tribunal noted that Dr Demanya admitted paragraph 1(a)(v)(i).

68. The Tribunal dealt with these matters together as alternatives. It is clear there was confusion on the part of Dr Demanya as to the precise role of Dr D, which is understandable in the circumstances as made known to the Tribunal.

69. The Tribunal had regard to Dr Demanya's evidence to the Tribunal. He said that he contacted the 'Medical Registrar' on the number provided to him by one of the nurses. The

number activated a bleeper system for the relevant doctor and in this case it bleeped Dr D. Dr Demanya said he assumed Dr D was the Medical Registrar, and Dr D did nothing to disabuse him of that belief. Dr D accepts he did not state he was not the Registrar. The Tribunal was satisfied that Dr Demanya reasonably believed he was speaking to the Registrar.

70. The Tribunal then had regard as to whether the discussion between Dr Demanya and Dr D was sufficient to satisfy this limb of the allegation.

71. The Tribunal noted that Dr Demanya had instigated various investigations which included the taking of bloods, stool cultures and x-rays. It was not disputed that Dr Demanya spoke with Dr D at around 03:30 when he had the x-ray card which he was taking to the radiology department. The Tribunal has noted the conversation between Dr Demanya and Dr D in paragraphs 13 – 16 of Dr D's statement, as set out in the Tribunal's consideration of paragraph 1(a)(iv)(1) of the Allegation above.

72. Dr F in his report, dated 13 March 2022, stated in this regard:

> *'.... Dr D stated that he recalls being approached by Dr Demanya at around 0330 hours for advice about a patient with AKI and abdominal pain. He stated that he will be happy to accept the patient after a surgical cause had been ruled out. He also went on to state that he had not been made aware of how unwell Patient A and that he only discovered that when he reviewed Patient A at 0700 and saw the blood gas that had been done at 0229 hours.*
>
> *It this version of events is accepted, this would raise the concern of a failure to appropriately escalate the seriousness of Patient A's condition.'*

73. The Tribunal has already found Dr D's evidence the more credible version. The Tribunal has determined that the evidence as a whole shows that Dr Demanya did not diagnose and was not treating sepsis, and this is consistent with Dr D's account of what was told to him. The Tribunal was aware that it must avoid 'recycling' evidence, in that having used Dr D's account to help determine sepsis was not diagnosed, it should not then simply use that determination to establish the credibility of Dr D's statement. It is, however, a logical consistency that having determined Dr Demanya did not appreciate the seriousness of Patient A's condition, he did not adequately escalate it. It does not add to the gravity of the failings established.

74. The Tribunal notes paragraph 1(a)(v)(i) is admitted and found proved and it found paragraph 1(a)(v)(ii) proved.

<u>Paragraph 1(b)(i)</u>

1. On 26 February 2019 you were involved in the care of Patient A at Royal Glamorgan Hospital and you:

   b. retrospectively added:

i. antibiotics to Patient A's prescription chart;

75. The Tribunal has already found in respect of paragraph 1(a)(iii)(2) that Dr Demanya failed to prescribe antibiotics to Patient A within an adequate time period, and certainly not before 05:50, as set out in detail above. Dr Demanya has accepted that the handwriting is his, that he wrote the prescription for antibiotics. The only account he has offered to the Tribunal is that the antibiotics were written up at or around 03:40, which the Tribunal did not accept. It therefore follows that the Tribunal is satisfied that the prescription was written 'retrospectively'.

76. The Tribunal therefore found paragraph 1(b)(i) of the Allegation proved.

Paragraph 1(b)(ii)

1. On 26 February 2019 you were involved in the care of Patient A at Royal Glamorgan Hospital and you:

b. retrospectively added:

ii. 'catheterise…intake/output monitoring' to your treatment plan in Patient A's medical record;

77. The Tribunal has already found in respect of paragraph 1(a)(iv)(2) that Dr Demanya failed to include catheterisation as part of his treatment plan for Patient A. Dr Demanya has accepted that the handwriting is his, that he wrote the instruction to catheterise. The only account he has offered to the Tribunal is that this was written immediately after the examination at 03:00 was concluded, which the Tribunal did not accept. It therefore follows that the Tribunal is satisfied that this instruction was written retrospectively.

78. Therefore, for the reasons set out in relation to paragraph 1(a)(iv)(2), the Tribunal determined that Dr Demanya had not included catheterisation in his initial treatment plan for Patient A and that he added this retrospectively.

79. The Tribunal therefore found paragraph 1(b)(ii) of the Allegation proved.

Paragraph 1(c)

1. On 26 February 2019 you were involved in the care of Patient A at Royal Glamorgan Hospital and you:

c. crossed out the antibiotic prescriptions in Patient A's prescription chart without a valid reason for doing so;

80. In his statement, dated 16 February 2023, at paragraphs 101 and 102 stated:

'101. I did not cross out my antibiotic prescriptions and I particularly reiterate the

> *matters set out at paragraphs 61 to 63 above. As explained above, if I was going to cancel a prescription, I would put a line through it, initial or sign this, date and time it, and then explain my reason for doing so in the records.*
>
> *102. In the event, I had no reason for cancelling the antibiotics I had prescribed given my diagnosis of sepsis and my view that immediate antibiotic treatment was required.'*

81. During his evidence to the Tribunal Dr Demanya maintained that he had included antibiotics as part of his treatment plan for Patient A. He said that he had repeatedly chased up with the nursing staff as to why the antibiotics had not been administered.

82. The Tribunal reminded itself that Dr Demanya originally stated he had written the prescription directly after the 03:00 examination. His evidence in his statement and before the Tribunal was that it was written at 03:40. He accepts that at the time when Dr D arrived antibiotics had not been administered.

83. In paragraph 24 of her statement, Nurse C stated:

> *'24. Dr Demanya came into Patient A's room with prescription chart while I was attempting to cannulate, he showed me the prescription chart between 07:15am and 07:20am with IV antibiotic written on the chart. On the prescription chart the antibiotics amoxicillin and metronidazole had been added to the chart. I didn't see Dr Demanya writing those antibiotics down. Dr Demanya then said 'the morning team are here, and they are arranging to take Patient A to resuscitation unit. They can cannulate', I then saw him cross out the antibiotics on the prescription chart. When he was crossing it out I said 'No, don't. I am trying to cannulate her and I can give the antibiotics when I insert the cannula' but he crossed out the medications. Please find that prescription chart attached as* ***Exhibit LU4****.'*

84. The inference put before the Tribunal is that Nurse C was not telling the truth, and that she crossed out the prescription to cover for her failure to administer the prescription. The Tribunal has already noted its concern as to the reliability of some details of Nurse C's account, and the manner of her record keeping. However, it found no evidence to question her integrity and honesty. On the contrary the Tribunal bore in mind the significant changes in Dr Demanya's account of the writing of the prescription. It had found that he did not include catheterisation as part of his initial treatment plan as he has claimed. The Tribunal noted that at the time Nurse C states she saw Dr Demanya cross out the prescription for antibiotics, he would have been aware that his care and treatment of Patient A was likely to be questioned.

85. On the other hand, the Tribunal gives proper regard to Dr Demanya's good character and recognises the force in the argument put forward by his counsel that it would make little sense for him to cross out the prescription if he had just written it. The Tribunal has avoided speculating as to the actors' intent and motive, but was aware that at this point Dr Demanya had recently had a conversation with Dr D at 06:30 and that Dr D had raised concerns about the care and treatment of Patient A. It was the Tribunal's view that as Nurse C stated she

witnessed Dr Demanya cross out the prescription there was a binary choice: she gave a false account to cover her own actions, or he did. Taking into account all the circumstances of the morning as the evidence had established them to have happened, the Tribunal was of the view that on the balance of probabilities it was more likely that Nurse C was telling the truth and that Dr Demanya did cross out the prescriptions for the antibiotics.

86. The Tribunal found paragraph 1(c) of the Allegation proved.

Paragraph 1(d)(i)

1. On 26 February 2019 you were involved in the care of Patient A at Royal Glamorgan Hospital and you:

d. failed to record:

i. why you had crossed out the antibiotic prescriptions in Patient A's prescription chart;

87. By virtue of its finding in relation to paragraph 1(c), it follows that paragraph 1(d)(i) of the Allegation is found proved.

Paragraph 1(d)(ii)

1. On 26 February 2019 you were involved in the care of Patient A at Royal Glamorgan Hospital and you:

d. failed to record

ii. that 'catheterise…intake/output monitoring' had been retrospectively added to your treatment plan in Patient A's medical record.

88. By virtue of its finding in relation to paragraphs 1(a)(iv)(2) and 1(b)(ii), it follows that paragraph 1(d)(ii) of the Allegation is found proved.

Paragraph 2

2. On 25 February 2020 you made a false representation to the Coroner in that you stated:

a. you prescribed antibiotics to Patient A as part of your treatment plan, or words to that effect;

b. that catheterisation and/or urinary output monitoring was part of your treatment plan, or words to that effect.

89. The Tribunal considered paragraphs 2(a) and 2(b) together.

90. The Tribunal was provided with a copy of the transcript of the evidence given by Dr Demanya at the Coroner's inquest. Dr Demanya accepted the accuracy of the transcript.

91. In his statement, dated 16 February 2023, at paragraphs 104 – 108, Dr Demanya said:

'104. These charges are denied. Whilst I accept that I stated to the Coroner that I prescribed antibiotics to Patient A as part of my treatment plan (or words to that effect), and that catheterisation and/or urinary output monitoring was part of my treatment plan (or words to that effect), such representations were true.

105. For the avoidance of doubt, as regards charge 2(a), and as set out above, when I gave evidence to the Coroner I genuinely thought that I had written all of my prescriptions (i.e. including the antibiotics) on the drug chart at exactly the same time, and I entirely accept that is reflected in my evidence in the Inquest. Furthermore, and again as set out above, having now had the opportunity to reflect on the records at length, I do not think that is correct. Having carefully reviewed the records, my recollection is that: having prescribed the two bags of saline and the paracetamol, I then checked if Patient A's blood results were back; I reviewed and printed out the FBC results at 03.42; and then I returned to the cubicle and added the prescriptions for the two IV antibiotics to the drug chart.

106. However, the antibiotics were still prescribed as part of my initial treatment plan, having been documented on the drug chart very shortly after I had documented the prescriptions for saline and paracetamol.

107. Therefore, whilst at the time of the Inquest I genuinely, albeit mistakenly, thought that I had written all of my prescriptions (i.e. including the antibiotics) on the drug chart at exactly the same time, and gave that evidence, there was no false representation to the Coroner in stating that I had prescribed antibiotics to Patient A as part of my treatment plan: as set out above, the antibiotics were prescribed as part of my treatment plan.

108. As to charge 2(b), catheterisation and urinary output monitoring were part of my treatment plan, as documented contemporaneously during my initial assessment of Patient A at around 03:00.'

92. The Tribunal had already found that Dr Demanya had not prescribed antibiotics within an adequate time period for Patient A. This would render his statement to the Coroner false on either version of the timings that he has proposed. The Tribunal also established that the entry on the Cas Card that a catheter should be fitted to Patient A was not completed in the timeframe he offered to the Coroner. For those reasons, the Tribunal finds that Dr Demanya made a false representation to the Coroner. It therefore found paragraphs 2(a) and 2(b) of the Allegation proved.

Paragraph 3 (a)

3. You:

a. added the entries mentioned in paragraph 1b to give the false impression that they had been part of your treatment plan;

93. The Tribunal has already found proved that Dr Demanya had not included antibiotics as part of his initial treatment plan for Patient A and that Dr Demanya added them retrospectively.

94. The Tribunal has also found proved that the instruction to catheterise was also added retrospectively.

95. In the absence of any other explanation, the Tribunal, having taken account of its findings as set out in the paragraphs above, has determined that Dr Demanya added the entries mentioned in paragraph 1(b) of the Allegation retrospectively to give the false impression that they had been part of his treatment plan. No other explanation was offered by Dr Demanya or was apparent to the Tribunal on the evidence presented. It therefore found paragraph 3(a) in respect of paragraph 1(b) of the Allegation proved.

Paragraph 3 (b)(i) and (ii)

3. You:

b. knew, at the time of your actions set out in paragraph 1b and paragraph 2, that:

i. antibiotics had not been part of your treatment plan;

ii. catheterisation and urinary output monitoring had not been part of your treatment plan.

96. Dr Demanya has maintained that he did not conduct the actions set out in paragraph 1b of the Allegation retrospectively. Accordingly, no evidence has been provided to the Tribunal to allow it to determine that these actions could have been conducted any other way than knowingly.

97. As regards paragraph 2 of the Allegation, the Tribunal noted Dr Demanya's concerns as to the circumstances in which he prepared his statement to the Coroner. Nevertheless, he accepted that the transcript before the Tribunal was accurate.

98. The Tribunal also noted that Dr Demanya acknowledged that the account he gave to the Coroner regarding the timing of the prescription for antibiotics was in error. However, the Tribunal is satisfied that he intentionally and knowingly sought to mislead the Coroner, as

the Tribunal has already determined that the later version would also have been misleading. The clear intention of Dr Demanya was to present to the Coroner a false impression that antibiotics were prescribed at or near the outset of his management of Patient A.

99. As regards the catheterisation, no evidence has been presented to suggest the account as given to the Coroner was offered in error, and therefore the Tribunal can only determine it was given knowing it was false.

100. The Tribunal therefore found paragraph 3(b)(i) and (ii) in relation to paragraphs 1(b) and paragraph 2 of the Allegation proved.

Paragraph 4

4. Your action described at paragraph:

a. 1bi was dishonest by reason of paragraph 3a and 3bi;

b. 1bii was dishonest by reason of paragraph 3a and 3bii;

c. 2a was dishonest by reason of paragraph 3bi;

d. 2b was dishonest by reason of paragraph 3bii.

101. The Tribunal has considered paragraphs 4a, 4b, 4c and 4d together.

102. The Tribunal is aware of the Supreme Court judgment in the case of *Ivey v Genting Casinos (UK) Limited [2017] UKSC 67*, as set out above at paragraph 21 above.

103. The Tribunal found proved that Dr Demanya knowingly made the retrospective entries to the medical record to give the false impression they had been part of the original treatment plan, and knowingly gave false representations to the Coroner. The Tribunal has also found proved that he was aware of the clear importance of the integrity of the records he made and the account he gave to the Coroner. The Tribunal determined that any ordinary decent person would find his actions in such circumstances to be dishonest.

104. The Tribunal therefore determined that Dr Demanya's actions were dishonest as described at:

paragraph 1(b)(i) by reason of paragraph 3(a) and 3(b)(i);
paragraph 1(b)(ii) by reason of paragraph 3(a) and 3(b)(ii);
paragraph 2(a) by reason of paragraph 3(b)(i); and
paragraph 2(b) by reason of paragraph 3(b)(ii).

105. The Tribunal made the following findings:

1. On 26 February 2019 you were involved in the care of Patient A at Royal Glamorgan Hospital and you:

a. failed to:

i. make a specific diagnosis of severe infection;
Found proved

ii. consider a differential diagnosis of intra-abdominal infection or acute abdomen;
Determined and found not proved

iii. prescribe antibiotics to Patient A either:

1. at all; or
Determined and found not proved

2. within an adequate time period;
Found proved

iv. include as part of your treatment plan for Patient A:

1. referral to the surgical team;
Determined and found not proved (Admitted as a matter of fact only)

2. catheterisation and/or urinary output monitoring;
Found proved

v. escalate the seriousness of Patient A's condition to either the:

1. medical registrar on call; or
Admitted and found proved

2. emergency medicine consultant;
Found proved (Admitted as a matter of fact only)

b. retrospectively added:

i. antibiotics to Patient A's prescription chart;
Found proved

ii. 'catheterise…intake/output monitoring' to your treatment plan in Patient A's medical record;

Found proved

c. crossed out the antibiotic prescriptions in Patient A's prescription chart without a valid reason for doing so;

Found proved

d. failed to record:

i. why you had crossed out the antibiotic prescriptions in Patient A's prescription chart;

Found proved

ii. that 'catheterise…intake/output monitoring' had been retrospectively added to your treatment plan in Patient A's medical record.

Found proved

2. On 25 February 2020 you made a false representation to the Coroner in that you stated:

a. you prescribed antibiotics to Patient A as part of your treatment plan, or words to that effect;

Found proved (Initially admitted as a matter of fact only)

b. that catheterisation and/or urinary output monitoring was part of your treatment plan, or words to that effect.

Found proved

3. You:

a. added the entries mentioned in paragraph 1b to give the false impression that they had been part of your treatment plan;

Found proved

b. knew, at the time of your actions set out in paragraph 1b and paragraph 2, that:

i. antibiotics had not been part of your treatment plan;

Found proved

ii. catheterisation and urinary output monitoring had not been part of your treatment plan.

Found proved

4. Your action described at paragraph:

a. 1bi was dishonest by reason of paragraph 3a and 3bi;

Found proved

b. 1bii was dishonest by reason of paragraph 3a and 3bii;

Found proved

c. 2a was dishonest by reason of paragraph 3bi;

Found proved

d. 2b was dishonest by reason of paragraph 3bii.

Found proved

And that by reason of the matters set out above your fitness to practise is impaired because of your misconduct.

To be determined

Determination on Impairment - 02/05/2023

106. The Tribunal now had to decide, in accordance with Rule 17(2)(l) of the Rules, on the basis of the facts which it has found proved, whether Dr Demanya's fitness to practise is impaired by reason of his misconduct.

The Evidence

107. The Tribunal has taken into account all the evidence received during the facts stage of the hearing, both oral and documentary. In addition, the Tribunal received a Stage 2 defence Bundle, which included, but was not limited to:

CPD Certificates and Reflections on Courses and Reading

- Reflection following review of "The Septic Patient", 25 March 2019;
- Reflection following review of "Managing Fever", 26 March 2019;
- Reflection following review of "Diarrhoea - Management Of", 27 March 2019;
- Reflection following review of: NICE Guidance NG51 sepsis, Recognition, Diagnosis and Early Management, 4 April 2020;
- Challenges in hospital care: Sepsis – recognition and management in adults and Reflection, 7 April 2020;
- Investigating, assessing the risk to the patient and preparing a response to a

patient's complaint via the hospitals Complaints Management Unit, 6 August 2020;
- Adverse Outcomes - Using the ASSIST Model and Reflection, 9 May 2022;
- Medical Records in Secondary Care and Reflection, 9 May 2022;
- Preventing complaints and Reflection, 10 May 2022;
- Hospital presentations: Fever and Reflection, 28 January 2023;
- Complaint management in primary care and Reflection, 19 February 2023,
- How to make effective referrals: tips for newly qualified doctors and Reflection, 19 February 2023;
- Potassium management: Hyperkalaemia and Reflection, 19 February 2023;
- Survival guide: safe prescribing for patients in hospital – writing prescriptions, the drug chart, and medicines reconciliation and Reflection, 19 February 2023;
- Reflective Learning for Medical Professionals, 19 March 2023;
- Sepsis in Secondary Care and Reflection, 19 March 2023;
- Difficult Interactions with colleagues and Reflection, 19 March 2023;
- Communicating Risk: A Two-Way Conversation and Reflection, 20 March 2023;
- Understanding Human Factors to Improve Clinical Performance and Patient Safety and Reflection, 20 March 2023;
- Preventing Complaints and Reflection, 21 March 2023;
- Ethics and Ethical Standards for Doctors and Reflection, 27 March 2023
- Reflection on Medical Professionalism, 30 March 2023;
- Reflection on Interdisciplinary Team Issues, 2 April 2023;
- Module on Insight and Reflection, 4 April 2023;
- Writing a Report for the Coroner and Reflection, 16 April 2023;
- Reflections on the Allegations, 16 April 2023.

Teaching Material
- Presentation: Lecture on the topic of Sepsis, provided to foundation doctors at Hillingdon Hospital, by Dr Demanya, 15 February 2023;
- Letter from Dr H to Dr Demanya with feedback on Sepsis lecture, 16 February 2023.

Submissions for the GMC:

108. Mr Garside referred the Tribunal to the relevant legal principles when considering misconduct and impairment. He also referred the Tribunal to the relevant paragraphs of Good Medical Practice (2013) ('GMP') which he submitted were engaged in this case. He submitted that there had been gross breaches of GMP, namely paragraphs 19, 35, 36, 37, 65, 71, 72 and 73.

109. Mr Garside also referred the Tribunal to the 'Acting as a Witness in Legal Proceedings' Guidance, which he submitted applied to a doctor giving evidence as a witness of fact, as Dr Demanya did in the inquest hearing, in addition to covering the responsibilities of being an expert witness. He submitted that the guidance states that '*you have a duty to the Court and this overrides any obligation to the person who was instructed or paying you. This means you have a duty to act independently and to be honest, trustworthy, objective and impartial*.' Mr Garside also referred the Tribunal to those paragraphs of the Sanctions Guidance (November 2020)('SG') which deal with dishonesty.

110. In respect of the specific allegations, Mr Garside submitted that it was not the GMC's case that Dr Demanya had deliberately failed to treat Patient A appropriately, but that it was a failure of good clinical care. However, following his failure to diagnose severe infection, Dr Demanya took steps to '*cover up*' his error, and that the Stage 1 findings of the Tribunal support that proposition. He took the Tribunal through those findings in respect of the clinical failings. He submitted that in respect of the failure to escalate the seriousness of Patient A's condition, the GMC's case has always been that it was the conversation with Dr D which was defective, not the mistake as to his status. Dr D was not given sufficient information to allow him to understand the gravity of patient A's condition. He submitted however that the GMC accepted the failure to escalate, and the failure to prescribe antibiotics or catheterise, were not aggravating but natural consequences of Dr Demanya's initial failure of diagnosis.

111. Mr Garside submitted that the situation was, however, different as regards the elements of dishonesty which the Tribunal had found proven, and which constituted the '*cover up*'. He reminded the Tribunal that it had found that Dr Demanya retrospectively and dishonestly added antibiotics and catheterisation to Patient A's medical chart. The Tribunal had also found that Dr Demanya had crossed out the prescription for antibiotics, possibly at the point he had begun to realise that there were questions being raised about his treatment of Patient A. He submitted that those dishonest actions, along with Dr Demanya's false representation to the coroner, were all part of an ongoing effort to cover up his clinical failing.

112. Mr Garside submitted that even if the clinical failings stood alone, that would still constitute serious misconduct: Patient A was very ill, and it cannot be known what the outcome would have been if she had been given the appropriate treatment in a timely manner. He submitted that the allegations of dishonesty which related to the cover up undoubtedly amounted to serious misconduct.

113. Mr Garside then invited the Tribunal to consider whether this serious misconduct amounted to impairment. He submitted that in the light of the Tribunal's findings there is undoubtedly impairment of fitness to practice, arising either from the serious clinical failing, from the dishonesty which followed, or both.

114. In respect of Dr Demanya's dishonest conduct, Mr Garside reminded the Tribunal that dishonesty ordinarily led to a finding of impairment in the absence of exceptional circumstances. He submitted that there were no such circumstances present in this case and that it inevitably amounted to impaired fitness to practise.

Submissions for Dr Demanya

115. Mr Mellor referred the Tribunal to the Stage 2 defence bundle. Dr Demanya had provided reflections, which were prepared prior to having seen the Tribunal's Stage 1 determination. He submitted that given the Tribunal's findings of dishonesty, and Dr Demanya's full appreciation of the seriousness of those findings, it was accepted that a finding of serious misconduct must follow.

116. Mr Mellor submitted that Dr F's evidence was that some of the clinical allegations that have now been found proved relate to matters that would only be below the standard expected, and not seriously below, and therefore would not amount to misconduct on their own. Furthermore, he submitted, it could be argued that some of the other clinical allegations which Dr F considered would be seriously below the standard, did not constitute serious misconduct as they related to a single clinical incident. Mr Mellor conceded, however, given the serious findings of dishonesty it was accepted as inevitable by the doctor there would be a finding of serious misconduct.

117. In respect of impairment, Mr Mellor accepted that a finding of impairment must also follow based on those findings of dishonesty. He submitted that Dr Demanya fully appreciates the seriousness of those dishonesty findings, despite the fact that he denied them. He submitted that Dr Demanya appreciates that they amount to breaches of a fundamental tenet of the profession and the requirement to uphold professional standards and public confidence in the profession.

118. Mr Mellor submitted that he would wait to address the Tribunal on mitigation until what he accepted was an inevitable third stage. However, he submitted that he would like to highlight three matters.

119. Firstly, whilst Dr Demanya has denied the allegations of dishonesty in the vast majority of the clinical allegations, he has nevertheless undertaken a considerable amount of CPD in relation to the areas of concern that are raised from the allegations. He informed the Tribunal that this CPD related to matters including the management of sepsis, referrals, and probity and ethical standards. He referred the Tribunal to notes within the Stage 2 bundle which were the basis of lectures Dr Demanya had delivered to foundation doctors regarding sepsis.

120. Secondly, Mr Mellor submitted that prior to these findings, Dr Demanya was of good character with a previously unblemished medical career of nearly 20 years. He submitted that there had been no previous adverse fitness to practise findings. The extensive testimonials provided on behalf of Dr Demanya were strong evidence that dishonesty was out of character for him, and the clinical failings found were inconsistent with his proven ability as a doctor.

121. Thirdly, Mr Mellor submitted that no other issues have arisen in relation to Dr Demanya's probity or clinical practice in the more than four years since the events under consideration.

122. Mr Mellor also submitted that the Tribunal should reject Mr Garside's assertion that impairment should flow from the clinical misconduct alone. He submitted that even if the clinical failings the Tribunal had found proved were deemed of themselves to constitute serious misconduct, in the context of all the evidence, the time that has passed, and the lack of any repetition, it would be open to the Tribunal to find that there was no current impairment.

The Relevant Legal Principles

123. The Legally Qualified Chair gave advice on the approach to be taken by the Tribunal in relation to impairment.

124. The Tribunal reminded itself that, at this stage of proceedings, there is no burden or standard of proof and the decision of impairment is a matter for the Tribunal's judgement alone.

125. In approaching the decision, the Tribunal must be mindful of the two-stage process to be adopted: first whether the facts found proved amounted to misconduct which was serious; and secondly, whether the finding of serious misconduct should lead to a finding of impairment.

126. The Tribunal must determine whether Dr Demanya's fitness to practise is impaired today, taking into account his conduct at the time of the events and any relevant factors since then, such as whether the matters are remediable, have been remedied and any likelihood of repetition. It should also consider whether a finding of impairment is warranted taking into account the wider public interest.

127. Throughout its deliberations, the Tribunal must be mindful of its responsibility to uphold the overarching objective, as set out in the Medical Act 1983 (as amended). That objective is the protection of the public and involves the pursuit of the following:

a. to protect, promote and maintain the health, safety and wellbeing of the public;
b. to maintain public confidence in the profession;
c. to promote and maintain proper professional standards and conduct for members of the profession.

128. Whilst there is no statutory definition of impairment, the Tribunal is assisted by the guidance provided by Dame Janet Smith in the Fifth Shipman Report, as adopted by the High Court in *CHRE v NMC and Paula Grant [2011] EWHC 297 Admin*. The Tribunal noted that any of the following features are likely to be present when a doctor's fitness to practise is found to be impaired:

a. 'Has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or
b. Has in the past and/or is liable in the future to bring the medical profession into disrepute; and/or
c. Has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or
d. Has in the past acted dishonestly and/or is liable to act dishonestly in the future.'

129. When considering the issue of insight and remediation the Tribunal must bear in mind the guidance in the line of authorities including *Nicholas-Pillai v GMC [2009] EWHC 1048*

(Admin), Towuanghantse v GMC [2021] EWHC 681 and *Sawati v General Medical Council [2022] EWHC 283 (Admin).* Every accused person is entitled to put a robust defence, and maintenance of innocence at a Tribunal should not automatically result in a finding of failure of insight: it is of potential relevance, but its relevance should be properly considered in context. In particular, where a denied allegation involves an issue of dishonesty the Tribunal must consider whether the element of dishonest state of mind was a primary allegation and then the nature of the denial. It should also consider how far 'lack of insight' is evidenced by anything other than the rejected defence.

130. As regards the issue of dishonesty the Tribunal had reference to the case of *GMC v Nwachuka 2017 EWHC 2085 (Admin)* where it was confirmed that it is unusual for dishonesty not to result in impairment. The Tribunal was also directed to the case of *Nkomo v GMC 2019 EWHC 2625 (Admin)*, which states that dishonesty is generally difficult to remediate. The Tribunal was reminded however, that each case should be considered on its own individual facts and a finding of dishonesty does not automatically mean that a doctor's fitness to practise must be impaired.

The Tribunal's Decision

Misconduct

131. The Tribunal first considered whether the facts found proved amounted to serious misconduct. The Tribunal had regard to the following paragraphs of GMP which it considered to be engaged in this case:

> *"1. Patients need good doctors. Good doctors make the care of their patients their first concern: they are competent, keep their knowledge and skills up to date, establish and maintain good relationships with patients and colleagues, are honest and trustworthy, and act with integrity and within the law.*
>
> *19. Documents you make (including clinical records) to formally record your work must be clear, accurate and legible. You should make records at the same time as the events you are recording or as soon as possible afterwards.*
>
> *35. You must work collaboratively with colleagues, respecting their skills And contributions.*
>
> *36. You must treat colleagues fairly and with respect.*
>
> *37. You must be aware of how your behaviour may influence others within and outside the team.*
>
> *65. You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession.*

71. You must be honest and trustworthy when writing reports, and when completing or signing forms, reports and other documents. You must make sure that any documents you write or sign are not false or misleading.

a. You must take reasonable steps to check the information is correct.
b. You must not deliberately leave out relevant information.

72. You must be honest and trustworthy when giving evidence to courts or tribunals. You must make sure that any evidence you give or documents you write or sign are not false or misleading.

a. You must take reasonable steps to check the information.
b. You must not deliberately leave out relevant information.

73. You must cooperate with formal inquiries and complaints procedures and must offer all relevant information while following the guidance in ***Confidentiality****."*

Clinical failures

132. The Tribunal considered first Dr Demanya's failure to make a specific diagnosis of severe infection, prescribe antibiotics to Patient A within an adequate time period, or include catheterisation and fluids input/output monitoring as part of his treatment plan for Patient A.

133. The Tribunal also bore in mind that Dr Demanya failed to escalate the seriousness of Patient A's condition to either the medical registrar on call or the emergency medicine consultant. He retrospectively added antibiotics to Patient A's prescription chart and the entry 'catheterise…intake/output monitoring' to the treatment plan in Patient A's medical record, and crossed out the antibiotic prescriptions without a valid reason for doing so. Dr Demanya also failed to record why he had taken these actions. The Tribunal was of the view that these matters, though found proved and part of the clinical care of Patient A, in effect flowed from the initial failure of diagnosis and the consequent management plan devised by Dr Demanya, or were part of the dishonest cover up dealt with below.

134. The Tribunal had particular regard to the expert opinion of Dr F, who stated:

"The failure to prescribe or the crossing out of the antibiotic prescription without a valid reason would fall seriously below the standard expected. Seriously below because it is a demonstration of a failure to recognise the need for antibiotic in an unwell patient presenting with clinical features of sepsis. It is a demonstration of a lack of knowledge and skill in the recognition management of the unwell patients with clinical features of infection. This may have placed Patient A at a significant risk of harm and clinical deterioration."

135. The Tribunal accepted this expert opinion of Dr F. It was of the view that Dr Demanya's conduct, in respect of the clinical failures, and in particular, the failure to identify sepsis or prescribe antibiotics, were serious and would be considered serious by fellow medical practitioners.

136. The Tribunal therefore determined that Dr Demanya's actions in respect of his clinical failures amounted to serious misconduct.

Dishonesty

137. The Tribunal considered that there were two specific areas of dishonesty in this case. Firstly, Dr Demanya's attempts on the night of 26 February 2019 to cover up his failings by making false and retrospective entries and deletions in Patient A's medical notes and secondly, intentionally and knowingly seeking to mislead the Coroner by making false representations.

138. The Tribunal was satisfied that given the serious and continued nature of Dr Demanya's dishonesty, its potential impact of the care of Patient A and on the reputation of the profession and the standards expected, it constituted serious misconduct.

Impairment

139. Having determined that Dr Demanya's clinical failures and dishonesty amounted to serious misconduct, the Tribunal went on to consider whether his fitness to practise was impaired by reason of that misconduct.

140. In respect of Dr Demanya's clinical failures relating to his care of Patient A, the Tribunal was of the view they could be taken together as constituting a single failure of care, and that this failure should be viewed in the context of a twenty year period of practise. The Tribunal also considered that this failure was remediable.

141. The Tribunal then went on to consider whether the deficiencies which led to the clinical failures had been remediated. It had regard to the Stage 2 Bundle provided on Dr Demanya's behalf, including the CPD the doctor has undertaken, his reflections, and teaching material from a lecture he had provided on the topic of sepsis on 15 February 2023.

142. The Tribunal was satisfied that Dr Demanya had remediated his conduct in respect of his clinical failures and that the risk of repetition was low. It determined that in respect of his clinical failures, Dr Demanya's fitness to practise was not currently impaired.

143. The Tribunal was however of the view that his clinical failures and his dishonesty were inextricably linked. It was clear that Dr Demanya's dishonesty could have impinged on the clinical care provided to Patient A. In attempting to cover his failings by falsifying her records he could have prejudiced her subsequent treatment. In this regard Dr Demanya's misconduct breached many of the paragraphs of GMP as set out above.

144. The Tribunal concluded, however, that to import dishonesty into consideration of the clinical care could have the effect of 'double counting' that element of the misconduct.

145. The Tribunal then went on to consider the element of dishonesty itself. It was of the view that Dr Demanya's dishonest actions in making false entries and deletions in Patient A's

medical records and intentionally and knowingly seeking to mislead the Coroner by making false representations were of an extremely serious nature. The dishonesty related to serious matters at the heart of his professional duty and was of a sustained and calculated nature.

146. The Tribunal considered that there would need to be exceptional circumstances for a finding of dishonesty of this gravity not to amount to a finding of impairment. It found no such exceptional circumstances present in this case.

147. The Tribunal determined that all three limbs of the overarching objective were engaged, namely the need to protect, promote and maintain the health, safety, and wellbeing of the public; to maintain public confidence in the profession; and to promote and maintain proper professional standards and conduct for members of the profession.

148. The Tribunal determined that public confidence in the medical profession would be undermined if a finding of impairment were not made when such significant and prolonged dishonesty had been found, and that it would undermine professional standards. It was also of the view that it was contrary to the maintenance of the safety and wellbeing of the public for a doctor to falsify a patient's medical record.

149. For clarity and completion the Tribunal considered the four features of impairment, as set out by Dame Janet Smith, in the Fifth Shipman Report, and approved in *Grant* (see paragraph 23 above). The Tribunal was satisfied that all features were present in this case by way of Dr Demanya's dishonesty, but the Tribunal was not of the view that the failing in clinical care which he had demonstrated constituted a future risk of harm.

150. The Tribunal therefore determined that Dr Demanya's fitness to practise is currently impaired by reason of his misconduct.

Determination on Sanction - 06/12/2023

151. Having determined that Dr Demanya's fitness to practise is impaired by reason of misconduct, the Tribunal now has to decide in accordance with Rule 17(2)(n) of the Rules on the appropriate sanction, if any, to impose.

The Outcome of Applications Made during the Sanction Stage

152. Mr Mellor, counsel for Dr Demanya, raised with the Tribunal that certain documents had not been formally accepted by the Case Manager and accordingly made an application pursuant to rule 16(7)(a) to have these documents admitted into evidence. This application was not opposed by the GMC and the Tribunal granted Mr Mellor's application as being in the interests of justice.

The Evidence

153. The Tribunal has taken into account evidence received during the earlier stages of the hearing where relevant to reaching a decision on sanction.

154.The Tribunal received further evidence on behalf of Dr Demanya including:

- Testimonials in support of Dr Demanya from clinical colleagues and employers. These included testimonials from the clinical lead, clinical governance lead, medical director and chief operating officer of the Hillingdon Hospital, who all described Dr Demanya's dishonesty as being out of character;
- Evidence of Dr Demanya's Continuing Professional Development ('CPD');
- Dr Demanya's written reflections on his CPD courses, dated between June and November 2023;
- Dr Demanya's 'Development and Restoration Plan'.

Submissions

155. On behalf of the GMC, Mr Garside KC submitted that the appropriate sanction in this case was erasure. He noted that Dr Demanya still maintained his denial of wrongdoing. He submitted that whilst this continued denial should not be held as a reason for imposing a more severe sanction, it may be a factor to consider in relation to determination of insight and remediation. Mr Garside stated that the facts of the allegation, as established, should be at the centre of the Tribunal's decision, not Dr Demanya's denial.

156. Mr Garside noted that the Tribunal had not found Dr Demanya's fitness to practise impaired by reason of any clinical failings. He acknowledged the testimonial evidence that spoke to his clinical competence but submitted that all three limbs of the overarching objective were still engaged in this case as regards the dishonesty the Tribunal had found proved.

157. Mr Garside reminded the Tribunal that Dr Demanya's misconduct consisted of amending patient records and giving false evidence to the coroner's court, for the purpose of avoiding the blame for a clinical error. He submitted that Dr Demanya had allowed the blame to go onto others, which demonstrated a serious lack of probity and breached GMP guidelines to work collaboratively with colleagues, and that his dishonesty was thereby at the top end of seriousness. Mr Garside submitted that patient safety and professional standards required reliable and accurate notes to be made, public confidence required that he give honest and reliable testimony to the coroner, and the protection of professional standards required that doctors tell the truth and be accurate and reliable; all of these basic tenets Dr Demanya had undermined.

158. Mr Garside acknowledged as mitigating factors Dr Demanya's good character and obvious and attested clinical competence. He said that the Tribunal may also consider the lapse of time since the events to be a mitigating factor. Mr Garside accepted that Dr Demanya had made considerable effort to remediate his misconduct but submitted that this was a case where the misconduct was so serious and persistent as to be irremediable, as envisaged by paragraph 32 of the Sanctions Guidance (2020) ('the SG').

159. Mr Garside submitted that it could not be right to take no action in this case as there were no exceptional circumstances to justify such a course of action. He also submitted that conditions were not appropriate as they are most effective for addressing issues such as clinical failings.

160. Mr Garside referred the Tribunal to the paragraphs of the SG that deal with suspension. He said that suspension was most appropriate for cases that were serious but not so serious that the misconduct was '*fundamentally incompatible with continued registration*'. He submitted that the misconduct in this case was of such a nature, at the top end of serious, and therefore erasure was the appropriate sanction.

161. Mr Garside referred the Tribunal to paragraph 108 of the SG:

> *'108 Erasure may be appropriate even where the doctor does not present a risk to patient safety, but where this action is necessary to maintain public confidence in the profession. For example, if a doctor has shown a blatant disregard for the safeguards designed to protect members of the public and maintain high standards within the profession that is incompatible with continued registration as a doctor.'*

162. Mr Garside submitted that Dr Demanya had continued to maintain his dishonest account of events and that his notes were accurate even a year later at the coroner's court. He submitted that this was not a single incident but a persistent and sustained course of conduct, culminating in giving false evidence on oath. He said that Dr Demanya had shown a blatant disregard for the need to maintain public confidence and proper professional standards.

163. Mr Garside also referred the Tribunal to paragraph 109 of the SG and submitted that the following factors were relevant in this case:

> *'109 Any of the following factors being present may indicate erasure is appropriate (this list is not exhaustive).*
>
> *a A particularly serious departure from the principles set out in Good medical*

practice where the behaviour is fundamentally incompatible with being a doctor.

b *A deliberate or reckless disregard for the principles set out in Good medical practice and/or patient safety.*

…

d *Abuse of position/trust (see Good medical practice, paragraph 65: 'You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession').*

…

h *Dishonesty, especially where persistent and/or covered up (see guidance below at paragraphs 120–128).*

i *Putting their own interests before those of their patients (see Good medical practice paragraph 1: – 'Make the care of [your] patients [your] first concern' and paragraphs 77–80 regarding conflicts of interest).*

164. Mr Garside submitted that paragraphs (b) and (d) were relevant in this case because Dr Demanya was the senior clinician on duty within the team and had demonstrated a lack of candour and sought to blame others less senior, in order to protect his own interests. He also submitted that paragraph 109(j): *'Persistent lack of insight into the seriousness of their actions or the consequences'*, may be a matter that the Tribunal would wish to consider.

165. Mr Garside then referred the Tribunal to the section of the SG which deals with dishonesty. In particular:

'124 Although it may not result in direct harm to patients, dishonesty related to matters outside the doctor's clinical responsibility (eg providing false statements or fraudulent claims for monies) is particularly serious. This is because it can undermine the trust the public place in the medical profession. Health authorities should be able to trust the integrity of doctors, and where a doctor undermines that trust there is a risk to public confidence in the profession. Evidence of clinical competence cannot mitigate serious and/or persistent dishonesty.

125 Examples of dishonesty in professional practice could include:

…

b falsifying or improperly amending patient records

…

128 Dishonesty, if persistent and/or covered up, is likely to result in erasure.'

166. Mr Garside submitted that for these reasons, erasure was the most appropriate and proportionate sanction in this case.

167. Mr Mellor, Counsel for Dr Demanya, accepted that the arguments for erasure may well be forceful in the face of the type of prolonged dishonesty that the Tribunal had found proved. However, he submitted that there was exceptional mitigation in this case to show that erasure was unnecessary, and that a lengthy period of suspension would be appropriate and proportionate.

168. Mr Mellor accepted that it may be difficult to remediate dishonesty but disagreed with Mr Garside's submission that this was a case where the misconduct was irremediable. He submitted that, although dishonesty may be difficult to remediate, each case turned on its own facts. Mr Mellor told the Tribunal that Dr Demanya had engaged in significant remediation work, which included attending the 'gold standard' professional ethics course as well as attending one-to-one medical ethics training. He said that Dr Demanya's reflections on these courses demonstrated his full insight into the gravity of the findings made at the facts and impairment stages as well as an understanding of the adverse impact those actions could have on patients, colleagues and confidence in the profession.

169. Mr Mellor submitted that, notwithstanding his denial of dishonesty, there was evidence of Dr Demanya's insight and that he had taken considerable steps to reassure the Tribunal that no such dishonest behaviour would occur in the future. He said that this was further demonstrated by Dr Demanya's development and restoration plan.

170. Mr Mellor referred the Tribunal to the testimonial evidence, including that of officers at the Hillingdon Hospital, where Dr Demanya has continued to work since 2004. In particular, these included Dr J, divisional medical director for unplanned care, Dr K, clinical governance lead, Dr I, educational supervisor and appraiser and Ms Benson, chief operating officer. He told the Tribunal that these testimonials were made in the full knowledge of the stage 1 and 2 findings of the Tribunal, and nevertheless they were consistent in their opinion that Dr Demanya's clinical skills were high and that the dishonesty found by the Tribunal was out of character. It was also a common theme that they hoped he would continue to work with them at Hillingdon, and indeed that they relied upon him doing so. Mr Mellor submitted that these testimonials in such circumstances constituted exceptional evidence which rendered erasure a disproportionate sanction.

171. Mr Mellor submitted that, despite the seriousness of the Tribunal's findings, when taken in the context of Dr Demanya's career as a whole and with the testimonial evidence, his misconduct should not be considered to be fundamentally incompatible with continued registration. He said that there was no evidence of deep-seated personality or attitudinal

issues; Dr Demanya was of good character with no other history of regulatory concerns and had good insight into the misconduct proved against him.

172. Mr Mellor also referred the Tribunal to the table at page 30 of the SG, which sets out examples of aggravating factors that would be relevant to determining the period of a suspension. This table includes *'The extent of the doctor's significant or sustained acts of dishonesty or misconduct.'* Mr Mellor submitted that this made it clear that the SG envisaged circumstances where suspension would be an appropriate sanction for '*sustained dishonesty*' but accepted that such a suspension would inevitably be lengthy.

173. Mr Mellor submitted that erasure was not the only means of protecting the public in this case and that, in the context of his career as a whole and the exceptional testimonial evidence, Dr Demanya's misconduct was not fundamentally incompatible with continued registration. Mr Mellor set out the personal impact that erasure would have on Dr Demanya, and also submitted that there was a strong public interest in keeping such a skilled and experienced doctor on the register.

The Tribunal's Determination on Sanction

174. The decision as to the appropriate sanction to impose, if any, is a matter for the Tribunal exercising its own judgement. In reaching its decision, the Tribunal has taken into account the SG and the statutory overarching objective.

175. The Tribunal bore in mind that the reason for imposing sanctions is to uphold the overarching objective to protect the public. Sanctions are not imposed to punish doctors, although they may have a punitive effect.

176. The Tribunal took a proportionate approach, balancing the interests of Dr Demanya with the public interest. It bore in mind that the reputation of the profession as a whole is more important than the interests of any individual doctor.

177. The Tribunal is the final arbiter of sanction but should bear in mind the guidance of Sir Thomas Bingham MR in *Bolton v Law Society [1994] 1 WLR 512* at 598) [51] that *'in cases of significant professional dishonesty, mitigation has a necessarily limited role.'* The Tribunal was also directed to the case of *Nkomo v GMC 2019 EWHC 2625 (Admin)*, which states that whilst dishonesty is generally difficult to remediate and serious, particularly where sustained and covered up, each case should be considered on its own individual facts and a finding of dishonesty does not automatically mean that a doctor's fitness to practise must be impaired or that erasure must follow.

178. When considering the issue of insight and remediation the Tribunal must bear in mind the guidance in the line of authorities including *Nicholas-Pillai v GMC [2009] EWHC 1048 (Admin), Towuanghantse v GMC [2021] EWHC 681* and *Sawati v General Medical Council [2022] EWHC 283 (Admin)*. Every accused person is entitled to put a robust defence, and maintenance of innocence at a Tribunal should not automatically result in a finding of absence of insight: it is of potential relevance, but its relevance should be properly considered in context. In particular where a denied allegation involves an issue of dishonesty the Tribunal must consider whether the element of dishonest state of mind was a primary allegation and then the nature of the denial. It should also consider how far 'lack of insight' is evidenced by anything other than the rejected defence.

Aggravating and Mitigating factors

179. The Tribunal reminded itself of the circumstances of the case. It had found paragraphs of the Allegation relating to clinical issues proved, and of a serious nature, but that these issues were remediated and did not lead to a finding of impairment. Dr Demanya's fitness to practise was impaired because he had dishonestly amended Patient A's records and made false representations under oath in the coroner's court.

180. The Tribunal considered that the following were aggravating factors in this case:

- Dr Demanya's repeated and sustained dishonesty as regards Patient A's, which actions continued over the course of a year;
- The inherent and clear gravity of creating false patient records;
- The seriousness of lying to the coroner's court in a premeditated manner when giving evidence as to his professional conduct;
- The nature of Dr Demanya's misconduct was such that it inevitably deflected blame onto other junior colleagues;
- Multiple, serious breaches of GMP as already established.

181. The Tribunal considered the following to be mitigating factors in this case:

- Dr Demanya's previous good character;
- His clinical skills and career to date;
- The impressive nature of the accumulative testimonial evidence.

No Action and Conditions

182. The Tribunal considered that no exceptional circumstances had been identified in this case to justify it taking no action. It also noted the submissions of both parties as to whether the imposition of conditions would be appropriate sanction in this case, and determined that

an order of conditions would be neither appropriate nor proportionate for the misconduct found proved.

Suspension and Erasure

183. The Tribunal had to assess the scope and seriousness of the misconduct in the context of all the circumstances of the case to determine whether Dr Demanya's conduct was fundamentally incompatible with continued registration. Paragraph 92 of the SG sets out:

> *'92 Suspension will be an appropriate response to misconduct that is so serious that action must be taken to protect members of the public and maintain public confidence in the profession. A period of suspension will be appropriate for conduct that is serious but falls short of being fundamentally incompatible with continued registration (ie for which erasure is more likely to be the appropriate sanction because the tribunal considers that the doctor should not practise again either for public safety reasons or to protect the reputation of the profession).'*

184. The Tribunal considered the following paragraphs of the SG as potential indicators that suspension may be sufficient to address the seriousness of his misconduct:

> *'97 Some or all of the following factors being present (this list is not exhaustive) would indicate suspension may be appropriate.*
>
> *...*
>
> *e No evidence that demonstrates remediation is unlikely to be successful, eg because of previous unsuccessful attempts or a doctor's unwillingness to engage.*
>
> *f No evidence of repetition of similar behaviour since incident.*
>
> *g The tribunal is satisfied the doctor has insight and does not pose a significant risk of repeating behaviour.'*

185. The Tribunal also accepted Mr Mellor's submission that the SG envisages the potential of suspension as an appropriate sanction for '*significant or sustained dishonesty*'.

186. Against that, the Tribunal considered that the dishonesty was a blatant disregard for basic principles of the profession, was fundamentally unprofessional and amounted to a significant breach of multiple paragraphs of GMP. The Tribunal had regard to the paragraphs of the SG identified by Mr Garside, as set out above, paragraph 15. It considered that the nature of Dr Demanya's misconduct clearly fell within these examples. Dr Demanya had fraudulently amended Patient A's record to protect himself from the potential consequences

of having made a clinical error. He continued with this dishonest cover up a year later at the coroner's court, giving false evidence under oath.

187. The Tribunal had particular regard to paragraph 128 of the SG:

Dishonesty, if persistent and/or covered up, is likely to result in erasure.'

188. For these reasons, the Tribunal was of the view that Dr Demanya's misconduct of itself was of such a serious nature that it was *'fundamentally incompatible with* [his] *continued registration'* (SG 97(a)) and that, accordingly, suspension was not an appropriate sanction. However, it then went on to consider Mr Mellor's submission that there was sufficient mitigation to justify suspension instead of erasure.

189. The Tribunal noted that the testimonial evidence was from many and various colleagues, including some very senior and respected professionals. It considered that this evidence was impressive in its consistency of view of Dr Demanya as a valuable and respected member of the team. It also noted the clarity of knowledge of the misconduct proved against Dr Demanya that these testimonials displayed, and that this did not dissuade them in their support for him. However, it considered that whilst the testimonials were of relevance to the assessment of risk of repetition and thereby public safety, they were of less assistance with the Tribunal's need to consider the wider public interest elements of the overarching objective.

190. The Tribunal accepted that the testimonials went a long way to address the concerns about risk of repetition. In light of this evidence, and after consideration of the evidence of insight and remediation provided, the Tribunal considered the risk to the safety and wellbeing of the public was low, but nevertheless still present. The dishonesty was of a serious nature and sustained for a lengthy period. Rather than admit a potential error, Dr Demanya embarked on a sustained 'cover up', which was fundamentally at odds with the professional standards he was required to display, and that inevitably diverted blame to his colleagues. The Tribunal was of the view that for this reason there remained a risk, albeit low, that such behaviour could be repeated if similar circumstances presented.

191. The Tribunal considered that whilst the testimonial evidence, taken with the evidence of insight and remediation shown by Dr Demanya, went some way to addressing the concerns regarding the safety of the public, it was of less assistance in relation to promotion of public confidence and maintenance of professional standards. The Tribunal found that the inherent seriousness of Dr Demanya's misconduct in falsifying Patient A's notes and giving false testimony under oath fundamentally undermined public trust in the profession, and that any sanction other than erasure would not appropriately promote and maintain professional standards.

192. The Tribunal accepted the submission on behalf of Dr Demanya that it was not in the public interest to lose an experienced clinician. However, it is a fundamental tenet of the sanctions regime, reflecting the overarching objective, that '*the reputation of the profession as a whole is more important than any individual doctor*' (SG paragraph 17). The Tribunal considered that there was nothing in the evidence before it to show circumstances to justify departing from its conclusion that the proper application of the guidance in the SG was that suspension was not a correct and proportionate sanction in this case.

193. The Tribunal determined that Dr Demanya had seriously undermined public confidence in the profession and had brought the profession into disrepute. It was also of the view that there remained a risk to public safety. Although this was mitigated to a considerable degree, for the reasons set out above, it remained a factor, and the Tribunal found that all three elements of the overarching objective were engaged in their decision as to the appropriate sanction. The Tribunal therefore determined for these reasons that it was necessary to erase Dr Demanya's name from the register to protect the wellbeing of the public, promote and maintain public confidence in the profession and to maintain proper professional standards.

Determination on Immediate Order - 06/12/2023

194. Having determined that Dr Demanya's name should be erased from the register, the Tribunal now has to decide, in accordance with Rule 17(2)(o) of the Rules, whether Dr Demanya's registration should be subject to an immediate order.

Submissions

195. On behalf of the GMC, Mr Garside, KC, submitted that an immediate order was necessary in this case. He referred the Tribunal to the relevant paragraphs of the SG and submitted that, despite there being no patient safety concerns in this case, the Tribunal had determined to erase Dr Demanya's name from the register for misconduct that was of a very serious nature. He submitted that the SG made it clear that an immediate order of suspension may be appropriate to protect public confidence in the profession.

196. On behalf of Dr Demanya, Mr Mellor, Counsel, submitted that an immediate order would not be necessary in this case, nor would it be proportionate. He told the Tribunal that Dr Demanya had been working under IOT conditions since the findings of fact and impairment and that these conditions had not been increased in light of those findings. He reminded the Tribunal that there had been no further concerns about Dr Demanya's conduct or clinical skills since the index events and submitted that, in circumstances where Dr

Demanya had been working since the impairment findings, it would be disproportionate to prevent him from working during the appeal period.

The Tribunal's Determination

197. In reaching its decision, the Tribunal has exercised its own judgement, taking into account all the circumstances. The Tribunal has borne in mind the guidance given in paragraphs 172 - 178 of the SG, in particular:

> *'172 The tribunal may impose an immediate order if it determines that it is necessary to protect members of the public, or is otherwise in the public interest, or is in the best interests of the doctor. The interests of the doctor include avoiding putting them in a position where they may come under pressure from patients, and/or may repeat the misconduct, particularly where this may also put them at risk of committing a criminal offence. Tribunals should balance these factors against other interests of the doctor, which may be to return to work pending the appeal, and against the wider public interest, which may require an immediate order.*
>
> *173 An immediate order might be particularly appropriate… where immediate action must be taken to protect public confidence in the medical profession.*
>
> *…*
>
> *178 Having considered the matter, the decision whether to impose an immediate order will be at the discretion of the tribunal based on the facts of each case. The tribunal should consider the seriousness of the matter that led to the substantive direction being made and whether it is appropriate for the doctor to continue in unrestricted practice before the substantive order takes effect.'*

198. The Tribunal accepted that an immediate order was not necessary to protect patients in this case. It also noted that Dr Demanya worked in the emergency department and did not have a list of regular patients who may be put at risk if an immediate order were imposed.

199. The Tribunal reminded itself of its findings as to the seriousness of Dr Demanya's misconduct and its determination on sanction that Dr Demanya's name should be erased from the register to protect public confidence in the profession and to promote and maintain proper professional standards.

200. The Tribunal considered it particularly serious that Dr Demanya had lied to the coroner, under oath, about the death of a patient. The Tribunal considered that the gravity and seriousness of this misconduct meant that the public confidence would require immediate action to be taken.

201. Considering paragraph 173 of the SG, the Tribunal was satisfied that an immediate order of suspension was appropriate in these circumstances and determined to impose such an order because of the serious nature of Dr Demanya's misconduct.

202. This means that Dr Demanya's registration will be suspended from today. The substantive direction, as already announced, will take effect 28 days from the date on which written notification of this decision is deemed to have been served, unless an appeal is made in the interim. If an appeal is made, the immediate order will remain in force until the appeal has concluded.

203. The interim order is hereby revoked.

204. This concludes the case.

ANNEX A – 12/04/2023

Rule 34(13) Application to hear evidence via videolink

205. On day 2 (12 April 2023) Mr Charles Garside KC, Counsel on behalf of the GMC, made application for the evidence of Nurse B to be heard via videolink under Rule 34(13) of the General Medical Council ('GMC') (Fitness to Practise) Rules 2004, as amended (the Rules). He advised the Tribunal that Nurse B had made herself available and has been in attendance at the MPTS hearing centre to give her evidence since 11 April 2023, which was originally the date she was scheduled to give her evidence. However she now needed to return home due to having child care responsibilities.

206. Mr Garside informed the Tribunal that the application had already been agreed with Dr Demanya's legal representative, Mr Mellor, and was therefore unopposed.

The Tribunal's Decision

207. The Tribunal had regard to Rule 34(13) and (14) which states:

> *'(13) A party may, at any time during a hearing, make an application to the Committee or Tribunal for the oral evidence of a witness to be given by means of a video link or a telephone link.*
>
> *(14) When considering whether to grant an application by a party under paragraph (13), the Committee or Tribunal must—*
>
> > *(a) give the other party an opportunity to make representations;*
> > *(b) have regard to—*
> >
> > > *(i) any agreement between the parties, or*
> > > *(ii) in the case of a Tribunal hearing, any relevant direction given by a Case Manager; and*
> >
> > *(c) only grant the application if the Committee or Tribunal consider that it is in the interests of justice to do so.'*

208. The Tribunal is mindful that the preference is to hear witness evidence in person. It has taken into account the submissions made by Mr Garside and the circumstances which led to the application being made. It has also taken into account that the application is unopposed. The Tribunal determined to grant the application.

ANNEX B – 17/04/2023

Rule 29(2) Application - to adjourn proceedings

209. On day 3 (13 April 2023) Mr Christopher Mellor, Dr Demanya's Counsel, made an application for the hearing to be adjourned until Monday 17 April 2023. XXX

210. Mr Garside informed the Tribunal of the GMC's position in relation to its witnesses but did not oppose the application.

The Tribunal's Decision

3. The Tribunal had regard to Rule 29(2) of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended ('the Rules'), which states:

> *"Where a hearing of which notice has been served on the practitioner in accordance with these Rules has commenced, the Committee or Tribunal considering the matter may, at any stage in their proceedings, whether of their own motion or upon the application of a party to the proceedings, adjourn the hearing until such time and date as they think fit."*

4. The Tribunal determined to grant Mr Mellor's application for a short adjournment of this hearing. It considered that it was fair and appropriate to do so as there was no reasonable alternative available. The hearing will reconvene at 09:30 am on Monday 17 April 2023.

ANNEX C – 17/04/2023

Rule 34(13) Application to hear evidence via videolink

211. On day 5 (17 April 2023) Mr Charles Garside KC, Counsel on behalf of the GMC, made an application for the evidence of Dr D to be heard via videolink under Rule 34(13) of the General Medical Council ('GMC') (Fitness to Practise) Rules 2004, as amended (the Rules). He advised the Tribunal that Dr D had made himself available and had attended in person at the MPTS hearing centre to give his evidence on 13 April 2023, however, it was not possible to hear his evidence. Mr Garside said that, due to his work commitments, Dr D was now unable to attend in person and he should therefore be allowed to give evidence via videolink.

212. Mr Mellor, on behalf of Dr Demanya, did not oppose the application.

The Tribunal's Decision

213. The Tribunal had regard to Rule 34(13) and (14) which states:

> *'(13) A party may, at any time during a hearing, make an application to the Committee or Tribunal for the oral evidence of a witness to be given by means of a video link or a telephone link.*

(14) When considering whether to grant an application by a party under paragraph (13), the Committee or Tribunal must—

(a) give the other party an opportunity to make representations;
(b) have regard to—

(i) any agreement between the parties, or
(ii) in the case of a Tribunal hearing, any relevant direction given by a Case Manager; and

(c) only grant the application if the Committee or Tribunal consider that it is in the interests of justice to do so.'

214. The Tribunal is mindful that the preference is to hear witness evidence in person. It has taken into account the submissions made by Mr Garside and the circumstances which led to the application being made. It has also taken into account that the application is unopposed. The Tribunal determined to grant the application.

ANNEX D – 21/04/2023

Rule 34(13) Application to hear evidence via videolink

215. On day 8 (20 April 2023) Mr Christopher Mellor, Dr Demanya's Counsel, made an application for the evidence of Dr I and Dr H to be heard via videolink under Rule 34(13) of the General Medical Council ('GMC') (Fitness to Practise) Rules 2004, as amended (the Rules). He submitted that both doctors are practising consultants and due to their work commitments, neither was able to travel to Manchester to give evidence in person. Mr Mellor added that it was in the interests of justice to allow their evidence to be given via videolink.

216. Mr Garside, on behalf of the GMC, did not oppose the application.

The Tribunal's Decision

217. The Tribunal had regard to Rule 34(13) and (14) which states:

'(13) A party may, at any time during a hearing, make an application to the Committee or Tribunal for the oral evidence of a witness to be given by means of a video link or a telephone link.

(14) When considering whether to grant an application by a party under paragraph (13), the Committee or Tribunal must—

(a) give the other party an opportunity to make representations;
(b) have regard to—

(i) any agreement between the parties, or
(ii) in the case of a Tribunal hearing, any relevant direction given by a Case Manager; and

(c) only grant the application if the Committee or Tribunal consider that it is in the interests of justice to do so.'

218. The Tribunal is mindful that the preference is to hear witness evidence in person. It has taken into account the submissions made by Mr Mellor and has taken into account that the application is unopposed. The Tribunal considered it was in the interest of justice to allow Dr I's and Dr H's evidence to be given via videolink. It therefore determined to grant the application.