PUBLIC RECORD

**Dates**: 10/06/2024 - 21/06/2024; 30/07/2024 - 02/08/2024

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| **Medical Practitioner's name:** | Dr Atila MORLOCAN |
| **GMC reference number:** | 7463991 |
| **Primary medical qualification:** | Doctor - Medic 2012 Titu Maiorescu University of Bucharest |

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

**Summary of outcome**

Suspension, 7 months.
Review hearing directed

**Tribunal:**

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| Legally Qualified Chair | Ms Louise Sweet KC |
| Lay Tribunal Member: | Mr Paul Curtis |
| Medical Tribunal Member: | Dr Nagarajah Theva |

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| Tribunal Clerk: | Ms Evelyn Kramer (10-14 and 18-21 June 2024)<br>Ms Maria Khan (17 June 2024)<br>Ms Ciara Fogarty (30 July – 2 August 2024) |

**Attendance and Representation:**

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| Medical Practitioner: | Present, represented |
| Medical Practitioner's Representative: | Ms Vivienne Tanchel, Counsel, instructed by CMS |
| GMC Representative: | Mr Ian Brook, Counsel |

## 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 - 21/06/2024

## Background

1. Dr Morlocan qualified in 2012 from Titu Maiorescu University of Bucharest, Romania with an MD in General Medicine. Dr Morlocan moved to the United Kingdom (UK) in 2014. He was employed at Epsom and St Helier University NHS Trust ('the Trust') as a clinical fellow in the Accident and Emergency Department ('A&E'). At the time of events, Dr Morlocan was practising as Specialty Doctor in A&E at the same Trust.

2. The Allegation that has led to Dr Morlocan's hearing can be summarised as, in July 2018 and May 2021, Dr Morlocan failed to provide good clinical care to Patient A and Patient D respectively. It is further alleged that between January 2019 and February 2022, when providing written and oral evidence to an inquest into Patient A's death, Dr Morlocan was dishonest.

3. The initial concerns were raised with the GMC in March 2020 by Ms C, Patient A's daughter.

## The Outcome of Applications Made during the Facts Stage

4. The Tribunal granted the GMC's application, made pursuant to Rule 34(1) of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'), to provide NICE Guidelines relied on by Dr I, a GMC Expert witness. The Tribunal's full decision on the application is included at Annex A.

5. The Tribunal refused the application made on behalf of Dr Morlocan, pursuant to Rule 17(2)(g) of the Rules, that there was no case to answer in respect of a number of paragraphs of the Allegation. The Tribunal's full decision on the application is included at Annex B.

## The Allegation and the Doctor's Response

6. The Allegation made against Dr Morlocan is as follows:

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

Patient A

1. You consulted with Patient A and did not provide good clinical care in that:

a. on 28 July 2018, you failed to:

i. obtain an adequate history;
To be determined

ii. carry out an adequate assessment;
To be determined

iii. in diagnosing sciatica, rule out significant alternative differential diagnoses;
To be determined

iv. make an adequate record of the consultation;
To be determined

v. (in the alternative to paragraph 1.a.i-1.a.iii) record carrying out the actions described in paragraph:

1. 1.a.i;
To be determined

2. 1.a.ii;
To be determined

3. 1.a.iii;
To be determined

b. on 29 July 2018 you prescribed diazepam, as set out in Schedule 1, at too high a dose;
Admitted and found proved

c. on 31 July 2018, you:

i. failed to:

1. obtain an adequate history;
To be determined

2. carry out an adequate assessment;
To be determined

3. in diagnosing sciatica, rule out significant alternative differential diagnoses;
To be determined

4. make an adequate record of the consultation;
To be determined

5. record that:

a. you had prescribed Tramadol;
To be determined

b. Patient A had discharged himself against medical advice;
To be determined

c. you had discussed with Patient A the safety of driving home after taking morphine;
To be determined

ii. inappropriately prescribed fentanyl patches ('the Prescription') as set out in Schedule 1:

1. at too high a dose for an opiate naïve patient;
   To be determined

2. when not clinically indicated for acute pain.
   To be determined

iii. failed to provide adequate safety netting advice in respect of the Prescription;
   To be determined

iv. (in the alternative to paragraphs 1.c.i.1 to 1.c.i.3 and 1.c.iii) failed to record taking the actions described in:

1. paragraph 1.c.i.1;
   To be determined

2. paragraph 1.c.i.2;
   To be determined

3. paragraph 1.c.i.3;
   To be determined

4. paragraph 1.c.iii.
   To be determined

2. On 31 July 2018 you inappropriately paid for the Prescription.
   Admitted and found proved

<u>Making a false statement to an inquest</u>

3. Between 28 January 2019 and 11 February 2022, in the course of providing written and/or oral evidence to the inquest into Patient A's death, you falsely stated that:

a. you had no further contact with Patient A's family after you met with Ms C on 7 August 2018;
   To be determined

b. Patient A told you that he was taking Tramadol;
   To be determined

c. Patient A told you that he had previously used fentanyl patches.
To be determined

4. You knew when you made the statement described at:

a. paragraph 3.a, that you had continued to exchange messages with Ms C via WhatsApp during August 2018 and September 2018;
To be determined

b. paragraph 3.b, that:

i. Patient A had not told you he was taking Tramadol;
To be determined

ii. a false claim that Patient A was taking Tramadol supported your decision to prescribe stronger pain relief;
To be determined

c. paragraph 3.c that:

i. Patient A had not told you that he had previously used fentanyl patches;
To be determined

ii. a false claim that Patient A had previously used fentanyl patches supported your purported belief that he was not 'opiate naïve'.
To be determined

5. Your actions at:

a. paragraph 3.a were dishonest by reason of paragraph 4.a;
To be determined

b. paragraph 3.b were dishonest by reason of paragraph 4.b;
To be determined

c. paragraph 3.c were dishonest by reason of paragraph 4.c.
To be determined

Patient D

6. On 24 May 2021 you consulted with Patient D and did not provide good clinical care in that in the presence of bilateral leg symptoms you failed to:

    a. consider possible cauda equina syndrome;
    To be determined

    b. arrange for Patient D to have an urgent MRI scan of her spine;
    To be determined

    c. refer Patient D for specialist assessment.
    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

7. At the outset of these proceedings, through his counsel, Ms Tanchel, Dr Morlocan made admissions to some paragraphs and sub-paragraphs of the Allegation, as set out above, in accordance with Rule 17(2)(d) of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended ('the Rules'). In accordance with Rule 17(2)(e) of the Rules, the Tribunal announced these paragraphs and sub-paragraphs of the Allegation as admitted and found proved.

8. In addition, Dr Morlocan indicated admissions to the paragraphs of the Allegation drafted in the alternative in respect of record keeping. It was agreed at the outset of proceedings that these indications would be recorded, but not formally accepted as admissions to avoid the potential for any inconsistency in the Tribunal's findings.

## The Facts to be Determined

9. In light of Dr Morlocan's response to the Allegation made against him, the Tribunal is required to determine the paragraphs and sub-paragraphs remaining.

## Factual Witness Evidence

10. The Tribunal received evidence on behalf of the GMC from the following witnesses:

- Ms C, Patient A's daughter, evidence heard in person. Witness statement dated 23 August 2021 and supplementary statement dated 19 November 2023;
- Mr E, Senior Pharmacist working at the Trust. Evidence heard by video link. Witness statement dated 3 January 2023;
- Dr F, locum Emergency Medicine Consultant at the Trust at the time of the events. Evidence heard by video link. Witness statement dated 9 February 2023;
- Dr H, General Practitioner (GP) at the Urgent Care Centre at the Trust, at the time of events. Evidence heard by video link. Witness statement undated.

11. Dr Morlocan provided his own witness statement, dated 27 February 2024, gave oral evidence at the hearing and relied on testimonials provided in support of his character and clinical practices.

## Expert Witness Evidence

12. The Tribunal also received evidence from two experts on behalf of the GMC. Dr I, a Consultant in Emergency Medicine, provided two reports, one report dated 26 August 2022 in respect of Dr Morlocan's treatment of Patient A and a second report dated 20 November 2022 in respect of Dr Morlocan's treatment of Patient D. Mr J, a Consultant in Emergency Medicine, provided a report dated 20 November 2023 in respect of the Dr Morlocan's treatment of Patient A.

## Documentary Evidence

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

- Excerpts of evidence received by the Coroner, including Dr Morlocan's statements to the Coroner dated 28 January 2019; 4 March 2020 and 3 February 2022, and a transcript of his oral evidence to the Coroner, dated 10 and 11 February 2022;
- WhatsApp and text messages exchanged between Dr Morlocan and Ms C, various dates between August and September 2018;
- Excerpts of Patient A's medical records;
- Excerpts of Patient D's medical records.

## The Tribunal's Approach

14. In reaching its decision on facts, the Tribunal has borne in mind that the burden of proof rests on the GMC and it is for the GMC to prove the Allegation. Dr Morlocan does not need to prove anything. 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.

15. In respect of the allegations that Dr Morlocan acted dishonestly, the Tribunal applied the test laid down by the Supreme Court in *Ivey v Genting Casinos (UK) Ltd* [2017] UKSC 67 *('Ivey'*), namely that the Tribunal should first ascertain subjectively the actual state of Dr Morlocan's knowledge or belief as to the facts. Whether the belief is reasonable may be a matter of evidence, but reasonableness is not an additional requirement when considering whether the belief was genuinely held. The Tribunal should then ascertain whether his conduct was dishonest applying the objective standards of ordinary decent people.

## The Tribunal's Analysis of the Evidence and Findings

Patient A

16. The Tribunal had regard to the chronology of events surrounding Patient A's treatment at A&E.

17. Patient A was an 80 year old man who attended A&E on 28 July 2018. He had leg pain and an inability to weight bear following firstly, a fall two weeks before and secondly, a facet joint injection five or six days earlier. After being triaged by a nurse and seen by Dr H at the Urgent Care Centre, Patient A was referred to A&E.

18. It was in A&E that Patient A and Dr Morlocan had their first interaction. Dr Morlocan diagnosed sciatica, prescribed Patient A co-codamol and diazepam for the pain he was in and showed him some exercises that gave such relief that it allowed Patient A to weight bear. During the consultation, Dr Morlocan asked for Patient A's mobile phone number to provide him with details of a physiotherapist.

19. Patient A attended A&E again on 29 July 2018. The clinical records from A&E about this attendance are missing but there are records about the investigations undertaken that day.

20. On 31 July 2018, Patient A attended A&E again and was treated by Dr Morlocan. Dr Morlocan prescribed medication of 4 tablets of tramadol, and subsequently on the same day he prescribed fentanyl patches at 50mcg to be taken once every 72 hours.

21. On 2 August 2018, Patient A sadly died.

22. On 7 August 2018, Dr Morlocan met with Ms C, Patient A's daughter outside the hospital. The messages referred to were exchanged before and after this meeting.

23. Between 10-11 February 2022 an inquest convened to consider Patient A's death. Dr Morlocan, Mr E, and Dr F provided written and oral evidence to the inquest. Dr F gave written evidence at the inquest.

24. Having set out the agreed background to Patient A's case, the Tribunal considered each outstanding paragraph of the Allegation in respect of Patient A separately and has evaluated the evidence to make its findings on the facts.

Paragraph 1.a.i, ii and iii

25. The Tribunal was required to determine whether when Dr Morlocan consulted with Patient A on 28 July 2018, he did not provide good clinical care in that he failed to obtain an adequate history, carry out an adequate assessment and in diagnosing sciatica rule out significant alternative differential diagnoses.

26. The Tribunal noted that the GMC case rested primarily on the lack of notes kept by Dr Morlocan in the consultations that reflected his asserted actions and the adverse inference that could be drawn from the same.

27. The Tribunal noted that Dr Morlocan had duties under paragraphs 16 and 21 of Good Medical Practice (2013) (GMP) to:

> ***16*** *In providing clinical care you must:*
>
> *a. prescribe drugs or treatment, including repeat prescriptions, only when you have adequate knowledge of the patient's health and are satisfied that the drugs or treatment serve the patient's needs*
>
> *b. provide effective treatments based on the best available evidence…*

*f. check that the care or treatment you provide for each patient is compatible with any other treatments the patient is receiving, including (where possible) self-prescribed over-the-counter medications*

***21*** *Clinical records should include:*

*a. relevant clinical findings*

*b. the decisions made and actions agreed, and who is making the decisions and agreeing the actions*

*c. the information given to patients*

*d. any drugs prescribed or other investigation or treatment*

*e. who is making the record and when.*

28. The Tribunal had regard to evidence before it regarding Patient A's first attendance at A&E on 28 July 2018. It had been provided with the triage notes, the notes made by Dr F, Dr Morlocan's own record of his consultation with Patient A and his written and oral evidence given to the Coroner. The Tribunal also had regard to Dr Morlocan's evidence in these proceedings.

29. When Dr Morlocan consulted with Patient A on 28 July 2018, it was agreed that he had sight of both the triage notes and Dr F's detailed notes. The Tribunal bore in mind that Dr Morlocan admitted that his notes of the consultation with Patient A on 28 July 2018 were inadequate. The Tribunal considered that a lack of an adequate note was an important consideration but not conclusive as to what did or did not happen in the consultation.

30. The GMC relied on the expert evidence of Dr I. In his report relating to Patient A's treatment, Dr I wrote:

*'Dr Morlocan has made no record of the symptoms experienced by Patient A, his past medical history, his drug history, details of any previous treatment for his conditions or any examination findings. In these circumstances I would have expected Dr Morlocan to have recorded the following information:*

- *Pain – location, radiation, severity, duration, exacerbating and relieving factors*
- *Pain relieving medication he was taking and its effectiveness*
- *Known allergies to medication*
- *Recent injections by the pain specialist*

- *Previous history of prostrate cancer*
- *Previous history of diabetes and high blood pressure*
- *Symptoms of numbness or "pins and needles" in the lower limbs*
- *Problems with bowel or bladder function. These are essential in the assessment of potential cauda equina syndrome*
- *General impression regarding level of discomfort*
- *Ability to walk*
- *Examination of back – visual examination, tenderness*
- *Ability to straight leg raise*
- *Neurological examination of lower limbs – tone, power, sensation and reflexes.*

*Based on his written record the standard of clinical assessment carried out by Dr Morlocan on 28.7.18 was seriously below the standard expected of a speciality doctor in emergency medicine.'*

31. In his witness statement, Dr Morlocan set out that after Dr F had handed over Patient A's care to him, he had:

*'I re-examined [Patient A] and my findings were the same as the GPs. Every time he put his foot down, it was triggering a pain response. The predominant finding was of acute pain from the buttock to the left knee. I reviewed the x-rays that showed some changes consistent with arthritis but no signs of malignancy.*

*I therefore agreed with the GP's primary diagnosis of sciatica…'*

32. In his oral evidence, Dr Morlocan described the steps he had taken to obtain a history from and examine Patient A. He detailed his recollection of the examinations he performed which he said reflected Dr I's evidence. Notwithstanding that he failed to record them, Dr Morlocan confirmed that the actions performed would have been his usual practice for any patient presenting with similar symptoms.

33. The Tribunal was not persuaded by the GMC's submission that Dr Morlocan's failure to set out these details in his witness statement to the GMC was because he was fabricating those recollections. The Tribunal noted that he had Dr I's expert report for some time 9 May 2023 and had plenty of opportunity to do so if he so wished. It could be inferred that he will have been guided by his legal team as to what should be contained in his statement. Dr Morlocan also said in evidence that some memories of the consultation had been provoked by seeing Dr F on the live link. Until the hearing, he had thought Dr F was female. Seeing his

face brought memories back of the consultation. The Tribunal was satisfied that memories can be triggered in unexpected ways.

34. The Tribunal accepted the submission by the GMC, supported by the evidence of Dr I, that without a record of the history obtained by Dr Morlocan and the assessment he carried out, that the reasonable inference to draw was that such actions had not been undertaken.

35. The Tribunal also bore in mind that Dr Morlocan is an Emergency Medicine doctor, working in a busy department. Dr Morlocan's evidence was that, on average, in a single A&E shift, he sees *'tens of patients'* per shift. At the time of these events, Dr Morlocan told the Tribunal that he had a *'patient focused'* consultation. His usual practice was not to keep contemporaneous records when consulting with the patient but to *'stack up'* his note taking and complete them all at the end of his shift. This meant that when he was completing the notes that he was not making a note contemporaneously. This approach, it could be inferred, inevitably, would leave to a shorter note being made for each patient and therefore not all actions carried out being recorded.

36. The Tribunal was mindful that Dr I had not been wholly critical of Dr Morlocan, he agreed with the diagnosis of sciatica made by both Dr F and Dr Morlocan. He had only criticised the lack of written justification for that diagnosis, the lack of a documented history and a lack of a recorded differential diagnosis. Nor had Dr I criticised Dr Morlocan for prescribing co-codamol and diazepam for Patient A and advising that Patient A seek physiotherapy.

37. The Tribunal was satisfied that for Dr Morlocan to have prescribed appropriate analgesia, he would have had to take a history and perform an assessment of Patient A.

38. The Tribunal also bore in mind that Dr Morlocan is of previous good character and has provided many testimonials in which his colleagues attest to his excellent patient care as an A&E doctor.

39. Whilst the criticisms of Dr Morlocan's note taking are well founded, on all the facts, the Tribunal could not be satisfied that he had failed to act in the ways alleged by the GMC.

40. The Tribunal determined that the GMC had not proved that it was more likely than not that Dr Morlocan had failed to undertake, rather than failed to record, obtaining an adequate history from, performing an adequate assessment of Patient A and recording significant alternative differential diagnoses on 28 July 2018.

41. The Tribunal found paragraphs 1.a.i., 1.a.ii, 1.a.iii of the Allegation not proved.

Alternatives

42. The Tribunal bore in mind Dr Morlocan's admissions, as indicated at the outset of these proceedings and repeated during his evidence, to paragraphs 1.a.iv, 1.a.v.1, 1.a.v.2 and 1.a.v.3 of the Allegation and found those paragraphs proved in the alternative. Dr Morlocan had failed in his duty to record the actions he carried out during his consultation with Patient A on 28 July 2018.

Paragraph 1.c.i

43. The Tribunal was required to determine whether, when Dr Morlocan consulted with Patient A on 31 July 2018, he did not provide good clinical care in that he failed to obtain an adequate history, carry out an adequate assessment and in diagnosing sciatica, rule out any significant alternative differential diagnoses.

44. The Tribunal noted that the GMC case for this allegation rested primarily on the adverse inference that could be drawn by the lack of a note to reflect these actions.

45. The Tribunal had regard to the relevant clinical records for Patient A's attendances at A&E. There were no allegations relating to 29 July 2018. The Tribunal was mindful that, despite having no clinical records for Patient A's attendance at A&E on 29 July 2018, various investigations were ordered and undertaken including x-rays and blood tests. Dr Morlocan gave an account of his consultation of Patient A on 29 July 2018 which was not challenged and appeared to be borne out by the recorded investigations.

46. The Tribunal considered Dr I's criticism of Dr Morlocan was based on the absence of a detailed record of the history taken, assessment completed and ruling out of significant alternative differential diagnoses. In respect of the treatment plan implemented by Dr Morlocan on 31 July 2018, Dr I was not critical, he confirmed that the medication that Dr Morlocan had prescribed whilst Patient A was in the hospital was *'reasonable and appropriate for the management of severe, acute back pain.'*

47. The Tribunal was satisfied that the records available demonstrated that Dr Morlocan had taken a dynamic or patient focused approach to Patient A's treatment. He had responded to Patient A's concerns about his pain at each A&E attendance and he had

ordered relevant investigations to rule out significant alternative differential diagnoses. The Tribunal accepted his evidence that that had left his note taking for 31 July 2018 until the end of the shift in a similar fashion to the 28 July 2018. This had detrimentally impacted the quality of his notes, so that the notes did not reflect all of his actions.

48. On all of the facts the Tribunal was not satisfied a lack of an adequate note meant actions had not been carried out as described by Dr Morlocan in his evidence.

49. Therefore, the Tribunal determined that the GMC had not proved that it was more likely than not that Dr Morlocan had failed to undertake, rather than failed to record, obtaining an adequate history from, performing an adequate assessment of Patient A and recording significant alternative differential diagnoses on 31 July 2018.

50. The Tribunal found paragraphs 1.c.i.1, 1.c.i.2 and 1.c.i.3 of the Allegation not proved.

Alternatives

51. The Tribunal bore in mind Dr Morlocan's admissions as indicated at the start of these proceedings and made during his evidence to the Tribunal to paragraphs 1.c.i.4 and 1.c.i.5.a-c of the Allegation and found those paragraphs proved in the alternative because Dr Morlocan had failed in his duty to record the actions he carried out during his consultation with Patient A on 31 July 2018.

52. The Tribunal also bore in mind Dr Morlocan's indicated admissions to paragraphs 1.c.iv.1, 1.c.iv.2 and 1.c.iv.3 of the Allegation and found those paragraphs of the Allegation proved.

Paragraph 1.c.ii.1

53. The Tribunal was required to determine whether, when Dr Morlocan consulted with Patient A on 31 July 2018, he did not provide good clinical care in that he inappropriately prescribed fentanyl patches at too high a dose for an opiate naïve patient.

54. The Tribunal first had regard to all the clinical information that was available to Dr Morlocan at the time he prescribed fentanyl patches to Patient A on 31 July 2018.

55. The triage note, which listed the medications made no reference to Patient A currently taking any opiates, at the time of his first attendance at A&E on 28 July 2018.

56. Dr F's note from 28 July 2018 said 'prev had tramadol which he said had helped a lot'. It was agreed that 'prev', was short hand for previously. There was evidence given at the inquest by Dr F as to what exactly 'previously' might have meant. Dr F stated he and the Coroner had settled on it meaning not currently. The word 'previously' does not assist this Tribunal as to when in time this refers to but its natural meaning supports Dr F's interpretation of his own note. Dr F now could not recall his consultation with Patient A in any detail. This was not surprising as it is now six years since the consultation. The GP notes were not available for the consultations for any clinician to check.

57. The Tribunal took into consideration the definition of *'opiate naïve'* provided by Mr J in words to the effect of *'someone who is currently not receiving opiates, has not been on opiates for any length of time or not taking opiates on a regular basis'.* When asked further about *'length of time'*, Mr J replied in words to the effect of *'not on a regular basis, for example a few weeks'.*

58. The Tribunal also noted that it was agreed that, even when a patient has used opiates before, they can become opiate naïve. It was evident that the tolerance or otherwise to opiates was vital knowledge when deciding if a drug should be prescribed and if so, in what dosage.

59. The Tribunal took into account paragraph 9 of the GMC guidance *Good practice in prescribing and managing medicines and devices* (2013 version) ('the Prescribing Guidance'):

> ***9*** *You must be familiar with the guidance in the British National Formulary (BNF) and British National Formulary for Children (BNFC), which contain essential information to help you prescribe, monitor, supply, and administer medicines.*

60. Dr Morlocan's stated that he prescribed four tablets of tramadol to Patient A after being advised by Patient A and/or his wife, that he had already been prescribed it for the pain he was experiencing. He accepted at the inquest that this was inconsistent with the triage notes. Dr I also accepted in his expert report, that the prescribing of tramadol for Patient A was reasonable if Dr Morlocan had been told this by the patient.

61. Dr Morlocan's evidence was that he took the decision to prescribe fentanyl patches due to Patient A's repeat attendances at A&E and his pain not being managed by the analgesics that had already been prescribed. He stated that, at the time of the prescription,

he believed that Patient A was not opiate naïve because he had told him he had previously taken opiates. He said he was told by Patient A that he had been prescribed tramadol and fentanyl. He said Patient A had told him that fentanyl patches had been prescribed in the context of pain relief for his bladder cancer. The Tribunal noted that the GP records showed that Patient A had, in the past, suffered bladder cancer. The records showed that Patient A had previously been prescribed opiates via patches, although this was buprenorphine not fentanyl and was in 2016. As noted, however, the GP records were not available to Dr Morlocan at the time of this consultation.

62. Dr Morlocan admitted in evidence that he was not aware that a patient who had a previous history of taking opiates could become opiate naïve.

63. Dr Morlocan now, in hindsight, accepts that the records show that Patient A was opiate naïve at the time he wrote the prescription. He also accepts that he should have made further enquiries to establish what medication Patient A was taking at the time and what he had previously taken to assist him in assessing Patient A's opiate tolerance.

64. Patient A's GP records, though not available to Dr Morlocan at the time of events, confirm that whilst Patient A had previously taken opiates, there was no record of any NHS prescription for them at the relevant time.

65. The Tribunal had regard to Mr J's expert evidence:

> *'Having decided to prescribe Fentanyl patches Dr Morlocan disregarded the dosage guidelines in the BNF of 12mcg/hr every 72 hrs and wrote a prescription for just over 4 times that dosage. There was no documented reasoning for this in the A&E record and no evidence from that record regarding any safety advice that was given.'*

66. Dr Morlocan, in his statement to the GMC, had suggested that it was Dr F, the consultant in charge of the shift, who had given him the dose to prescribe after he discussed his intended prescription with him. Dr F in evidence stated he had no memory of this conversation. He stated that a prescription of fentanyl was unusual from A&E and he had never prescribed it. In evidence Dr Morlocan stepped back from the assertion that Dr F advised him regarding the dosage and stated that he did not now have a clear recollection of how he calculated the dose for the fentanyl prescription. He stated he was the only person responsible for the prescription dose. He also accepted that had not queried the absence of any opiates in the triage note or any apparent inconsistency in the notes of Dr F.

67. The Tribunal was mindful of Mr J's evidence that the appropriate dosage guideline in the BNF for an adult, irrespective of whether they were opiate naïve or not, was 12mcg/hr every 72 hours. Dr Morlocan prescribed 50mcg/hr every 72 hours, which was over four times the recommended dose. The Tribunal noted that it may be readily inferred that either Dr Morlocan had either not properly read or not understood the BNF guidelines.

68. The Tribunal determined that Dr Morlocan had not provided good clinical care to Patient A because he had inappropriately prescribed fentanyl patches at too high a dose for Patient A, an opiate naïve patient.

69. The Tribunal found paragraph 1.c.ii.1 of the Allegation proved.

Paragraph 1.c.ii.2

70. The Tribunal was required to determine whether, when Dr Morlocan consulted with Patient A on 31 July 2018, he did not provide good clinical care in that he inappropriately prescribed fentanyl patches when not clinically indicated for acute pain.

71. The Tribunal accepted the evidence of Mr J in respect of the difference between chronic and acute pain namely that acute pain comes *'out of the blue'* suddenly either on day of presentation or shortly before. He gave examples that it might be pain resulting from minor surgical procedures or trauma. In contrast, he said chronic pain is persistent over some time. He explained that the timescale varies in different patients. Pain may start as acute and then become chronic in nature as it persists. Pain may fluctuate or vary in intensity. He stated a patient can have acute and chronic pain at the same time. The Tribunal considered that there was broad agreement about these definitions between the parties. It was agreed that, in respect of Patient A specifically, there was a mixed or *'blurred'* picture in terms of his pain.

72. The Tribunal noted the consistent description within Patient A's A&E records that Patient A was experiencing acute pain. The records state this pain arose as a result of a fall and a subsequent facet joint injection that had been sought as pain relief but failed.

73. Dr Morlocan had himself described Patient A's pain in his notes as '*…acute back pain and spasm'*. During his evidence, Dr Morlocan had introduced a further definition of acute, which he said was meant to describe the severity of Patient A's pain, rather than it being acute due to its sudden onset. This was not a definition that had been explored with Mr J.

74. The Tribunal had regard to the purpose of making a clinical record. Which, in part, is to allow future clinicians to comprehend why certain medication has been prescribed. The Tribunal was satisfied that another medical practitioner, reading the various accounts of Patient A presenting with *'acute pain'* would be more likely to conclude that 'acute' referred to the agreed medical definition as set out by Mr J rather than the different meaning now posited by Dr Morlocan.

75. Having concluded that Patient A was experiencing acute pain, the Tribunal had regard to the applicable Trust '*Guidelines for adult acute pain management'* dated 2017:

> *'**DO NOT** prescribed* [sic] *transdermal opioid patches for patients with acute pain. See trust guidance for information on prescribing and administering opioid patches'*

76. The Tribunal determined that Dr Morlocan had inappropriately prescribed fentanyl patches to Patient A when they were not clinically indicated because he was experiencing acute pain.

77. The Tribunal therefore found paragraph 1.c.ii.2 of the Allegation proved.

Paragraph 1.c.iii

78. The Tribunal was required to determine whether when Dr Morlocan consulted with Patient A on 31 July 2018, he failed to provide adequate safety netting advice in respect of the prescription.

79. The Tribunal again had regard to paragraph 21 of GMP which states:

> ***21** Clinical records should include:*
>
> *a. relevant clinical findings*
>
> *b. the decisions made and actions agreed, and who is making the decisions and agreeing the actions*
>
> *c. the information given to patients*
>
> *d. any drugs prescribed or other investigation or treatment*
>
> *e. who is making the record and when.*

80. The Tribunal has already accepted Dr Morlocan's evidence that he had on 31 July 2018 discussed with Patient A the safety, or not, of driving after taking morphine. He stated he had learned from the nurse that the patient was *'doing a runner'* so he had returned to see him and this was when he considered prescribing fentanyl and also was when he was asked by Patient A for tramadol. It was in that context that he advised Patient A not to discharge himself and that would not be safe for him to drive home. The Tribunal bore in mind that this amounted to some safety netting advice about the prescription of tramadol.

81. The Tribunal considered that Dr Morlocan should have given further safety netting advice with regard to the prescription of fentanyl. As already observed, this was a much stronger opiate. It was being given in a high dose. There was no record of safety netting advice being given by Dr Morlocan at all.

82. The Tribunal accepted that some of the safety netting advice was set out in the leaflet that came with the prescription, when it was dispensed.

83. Dr Morlocan did not see Patient A's wife when the Prescription was collected by her later in the day on 31 July 2018. He therefore did not speak to her or Patient A again at the hospital to explain the prescription leaflet contents, which the Tribunal accepts was both technical and lengthy.

84. It was Dr Morlocan's evidence that he spoke to Patient A's wife on the phone once she was at home to advise her to read the leaflet that accompanied the prescription. Subsequently, he said, Patient A's wife confirmed in a text message that she had read the leaflet.

85. The Tribunal considered that Patient A had been prescribed an extremely potent opiate. Dr Morlocan believed that Patient A was already prescribed tramadol, another opiate. Dr Morlocan had also prescribed him four tablets until he collected his prescription. The Tribunal considered that this was an elderly patient where care had to be taken to ensure the prescription and administration of the same was properly understood. When asked about his approach when he gave evidence Dr Morlocan noted that there was no issue with Patient A's ability to read or his capacity. The Tribunal considered that it was inadequate.

86. The Tribunal considered that Dr Morlocan did no more than refer Patient A/ his wife to the leaflet. The Tribunal did not accept that Dr Morlocan had discharged his duty to provide adequate safety netting advice by relying on Patient A/his wife's understanding of the leaflet.

87. Therefore, the Tribunal found paragraph 1.c.iii of the Allegation proved.

88. Accordingly, the Tribunal did not need to go on to consider paragraph 1.c.iv.4 of the Allegation as it was an alternative allegation.

Paragraph 3.a

89. The Tribunal was required to determine whether, between 28 January 2019 and 11 February 2022, in the course of Dr Morlocan providing written and/or oral evidence to the inquest into Patient A's death, he falsely stated that he had no further contact with Patient A's family after her met with Ms C on 7 August 2018.

90. The Tribunal noted that that it was agreed that WhatsApp and text messages were exchanged between Dr Morlocan and Ms C between August and September 2018. Ms C stated in oral evidence that there were also a number of phone calls between Dr Morlocan and herself after 7 August 2018. Dr Morlocan's evidence was that he had not remembered the exchange of those messages when giving evidence to the Coroner and he had not had access to the phone he was using at that time so no longer retained them himself.

91. The Tribunal noted that Dr Morlocan had not given evidence about his communication with the family at the inquest.

92. However, in respect of this paragraph of the Allegation, the GMC relied solely on a paragraph from Dr Morlocan's statement to the Coroner, dated 4 March 2020. Dr Morlocan stated:

> *'35. I had no further contact with the family save for a call from* [Ms C] *to my mobile phone some weeks later'*

93. The GMC had sought no amendment to this paragraph of the Allegation. It was evident the allegation was directed to an assertion of 'no contact' The Tribunal was of the view that to amend the paragraph at this stage of proceedings would amount to a significant unfairness to Dr Morlocan.

94. The Tribunal was concerned that Dr Morlocan had potentially not been entirely open in his statement to the inquest about the extent of his communication with Ms C. However, this was not what was alleged. The GMC alleged that Dr Morlocan had falsely stated that he

had no further contact with Patient A's family after 7 August 2018. In his statement to the Coroner, he confirmed that there had been further contact in respect of a phone call from Ms C weeks later, whilst this may not have reflected the extent of the contact, given the WhatsApp messages, it did not amount to a full denial of contact.

95. Therefore, the Tribunal found paragraph 3.a of the Allegation not proved.

Paragraph 3.b

96. The Tribunal was required to determine whether, between 28 January 2019 and 11 February 2022, in the course of Dr Morlocan providing written and/or oral evidence to the inquest into Patient A's death, Dr Morlocan falsely stated that Patient A had told him that he was taking tramadol.

97. Dr Morlocan had not recorded that he had prescribed Patient A tramadol. The Tribunal had regard to Dr Morlocan's evidence to the Coroner, in which he stated Patient A had told him he was taking tramadol. Regarding a lack of contemporaneous notes to validate this, Dr Morlocan told the Coroner:

> *'One of the issues that arises is I had issues with recording the real-time recommendations, so what I tended to do is focus on the patient's needs and then when I had time like half an hour, time to spare, I will write everything down, but in this case the only thing we've done is discussed and managed and then write my diagnosis and signed I think it.'*

98. The Tribunal took into consideration that there was no record in the GP notes that Patient A had taken tramadol since 2014. The records also evidenced that fentanyl had never been prescribed, although buprenorphine was prescribed in patch form in 2015. It was known that Patient A had been seeking private treatment for a pain relief injection but there was no evidence of private prescriptions before the Tribunal.

99. Dr Morlocan did not have access to the GP notes at the time of the relevant consultations, if he had he would have detected the inconsistency between them and the history he stated was given to him by Patient A.

100. The Tribunal had regard to the fact that the triage notes, the list of current medication and Dr F's notes do not include any explicit confirmation that Patient A was currently taking tramadol. Dr F's note recorded that Patient A had previously taken tramadol

and it had helped a lot. However, it was not clear what 'previously' meant in terms of the last time Patient A had taken tramadol. Dr Morlocan's evidence was that Patient A and Patient A's wife, both told him that Patient A was taking tramadol as pain relief. Dr Morlocan accepted this assertion was inconsistent with the history taken by his fellow medical practitioners and he also accepted, in his evidence to the Coroner, that he had not noted the patient's assertions in his own consultation notes nor raised the inconsistency with Patient A.

101. The Tribunal accepted Dr Morlocan's evidence that after he had spoken to Dr F about Patient A and reviewed the clinical records, he discussed pain relief with Patient A before prescribing any to him. It would be reasonable to infer that Dr Morlocan would have asked Patient A about his current and past medication to ascertain what was/ was not effective for managing his pain. Although there was an issue about when tramadol had been prescribed the use of tramadol was raised by Dr F as he had noted it. Dr Morlocan did have Dr F's note.

102. The Tribunal considered that it was unlikely, in the absence of being advised by Patient A that he was taking tramadol, that Dr Morlocan would have prescribed it. The Tribunal concluded that it could not fairly rule out that during the consultation Patient A had told Dr Morlocan that he was taking tramadol.

103. Accordingly, the Tribunal concluded that Dr Morlocan had not made a false statement in his evidence to the inquest.

104. The Tribunal found paragraph 3.b of the Allegation not proved.

Paragraph 3.c

105. The Tribunal was required to determine whether, between 28 January 2019 and 11 February 2022, in the course of Dr Morlocan providing written and/or oral evidence to the inquest into Patient A's death, Dr Morlocan falsely stated that Patient A had told him that he had previously used fentanyl patches.

106. The Tribunal noted that it was agreed there was no evidence in Patient A's clinical records or GP records that he had ever been prescribed fentanyl before although buprenorphine, another opiate, was prescribed in patch form to him in 2015.

107. The Tribunal was mindful that by the time Dr Morlocan prescribed fentanyl for Patient A, he had attended A&E three times due to the ongoing pain he was experiencing. Dr

Morlocan had already prescribed a range of analgesics to Patient A, none of which, according to Patient A were working to control his pain.

108. The GMC invited the Tribunal to infer that in the absence of a record of any discussion about fentanyl patches and the absence of evidence that Patient A had previously been prescribed fentanyl patches in his medical records, that Dr Morlocan had fabricated a conversation between himself and Patient A about fentanyl patches and his previous use of them. It is evident that the lack of a note was a serious omission when prescribing fentanyl patches, a strong opiate.

109. Dr Morlocan, in his evidence, could not recall how the topic of fentanyl was introduced into his conversation with Patient A. However, the Tribunal accepted that it may be reasonably be inferred that the topic of other and stronger pain relief in the context of ongoing pain is likely to have occurred.

110. It was not known if fentanyl as an option was raised by Dr Morlocan or Patient A. Given that Dr Morlocan did not have Patient A's GP records to hand, it might reasonably be inferred that Patient A must have confirmed he had used patches before. The Tribunal accepted that this would otherwise be a coincidence in the notes which he did not have sight of until recently. The GP notes evidenced that Patient A had previously received opiate pain relief in patch form. The Tribunal considered that it was likely therefore that Patient A had confirmed the use of opiate patches in the form of fentanyl or that Dr Morlocan had understood him to mean he had previously used fentanyl patches given the documented opiate patch use.

111. The Tribunal had regard to a message Dr Morlocan sent to Ms C between August and September 2018 after Patient A had sadly died. In his message, Dr Morlocan wrote:

> *'The patches were discussed with both of them the night before, to place all the painkillers that he was taking, as for the prescription and handed to the pharmacy, I payed for it because your mother told me that your father doesn't get exemption of pay, personally went to pharmacy to make sure that all the information is given in the pack, as fentanyl is a controlled drug it is mandatory to have the information leaflet, it won't be released without it, when I called to see how the massage went* [Patient A's wife] *confirmed that she had collected the prescription from the reception at hospital, and that she had read the leaflet'*.

112. This message was sent much closer to the time of events than any of the statements before the Tribunal. The Tribunal considered that this message indicated that, during his consultation with Patient A on 31 July 2018, Dr Morlocan had engaged in a discussion about fentanyl patches. *'The patches'* in the message could only refer to the prescription. If Dr Morlocan had not accurately reflected his discussion with Patient A and his wife about the fentanyl patches, he will have known that Patient A's wife was in a position to contradict this account.

113. The Tribunal considered that this message provided some support Dr Morlocan's contention that he had a discussion with Patient A in the consultation about fentanyl, in which Patient A had told him that he had previously used fentanyl patches.

114. The Tribunal had regard to Patient A's historic usage of opiate patches, Patient A's repeated attendance at A&E due to uncontrolled pain and the evidence that a conversation about fentanyl/opiate patches had occurred between Dr Morlocan, Patient A and his wife. The Tribunal considered the testimonials of Dr Morlocan which supported his honesty and integrity.

115. On all the evidence, the Tribunal concluded that it was more likely that Patient A had told him he used fentanyl patches or that there had been a breakdown in communication and that Dr Morlocan had misunderstood Patient A to be telling him that he previously used fentanyl patches rather than Dr Morlocan made a false claim to the inquest.

116. The Tribunal found paragraph 3.c of the Allegation not proved.

Paragraphs 4 and 5

117. Having determined that Dr Morlocan did not make false statements in evidence to the inquest as alleged, the Tribunal was not required to consider paragraphs 4 and 5 of the Allegation.

118. Accordingly, paragraphs 4 and 5 of the Allegation were found not proved in their entirety.

Patient D

Paragraphs 6.a, b and c

119. The Tribunal had regard to the chronology of events surrounding Patient D's treatment at A&E.

120. On 24 May 2021, an ambulance was called following Patient D having a fall and being unable to get up. It was recorded by the paramedic that for four weeks Patient D had been experiencing symptoms of bilateral sciatica and that the ambulance had been called because she was in significant pain after a fall and was unable to get up. The paramedics noted:

> *'pt has not had visual contact with GP but diagnosed over the telephone. She has been looking privately at options who are considering orthopedics …and physio but also considering MRI in the future'*

121. Once at A&E, Dr Morlocan had a consultation with Patient D. Dr Morlocan showed Patient D some exercises for her back, assisted her husband in helping with deep tissue massage and advised her to undertake the exercises after taking the diazepam that had been previously prescribed by Patient D's GP. Patient D successfully mobilised and was discharged from A&E without follow up.

122. On 1 June 2021, Patient D had a further fall and sustained an ankle fracture. After attending A&E, Patient D was referred for a magnetic resonance imaging (MRI) scan. She was diagnosed with Cauda Equina Syndrome and underwent surgery.

123. The Tribunal was required to determine whether, when Dr Morlocan consulted Patient D on 24 May 2021, he did not provide good clinical care in that in the presence of bilateral leg symptoms he failed to consider cauda equina syndrome, failed to arrange for an urgent MRI scan of her spine and failed to refer Patient D for specialist assessment.

124. In assessing whether the evidence demonstrated that Patient D was suffering from bilateral leg symptoms the Tribunal first reviewed the relevant clinical notes made on the day of the consultation.

a) The paramedics noted:

> *'…"Patient has been experiencing bilateral sciatica for 4 weeks, she thinks she jarred her back jumping off the side of a boat onto the gangway. Since then the pain radiates from her buttocks down both the backs of her legs. She denies saddle anaesthesia, no loss of bladder/ bowel. Patient has been experiencing weakness in her legs with them*

*giving out approximately 3 times previously with ambulance attending on Sunday but todays has now left patient unable to stand or take any of her own weight…"'*

b) The record was made by triage read: *'4 weeks of sciatica. GP given various analgesia. No saddle anaesthesia. Both of legs sides pain'.*

c) Dr Morlocan in his consultation notes recorded:

*'Patient explained that based on the examination she is having bilateral muscular spasms that give* [illegible word] *shooting pains to legs and that medication she is taking is only putting her to sleep* [illegible words].
*As such I showed a set of exercises that will allow the muscles to relax and minimize the* [illegible word] *of her pain.'*

125. The Tribunal considered the medical notes demonstrated clearly that Patient D had pain in both legs.

126. The Tribunal noted evidence arising from questions in cross-examination by Ms Tanchel, regarding the meaning of bilateral. Dr I gave evidence that *'presence of leg pain does not have to be in both legs at same time. Red flag symptom (in NICE guidelines) is for pain to be suffered in both legs.'* He also said *'I have no doubt that the patient had bilateral leg pain …. I am 100% certain there is no need for the pain to be in both legs simultaneously.'* There was no expert evidence called on behalf of Dr Morlocan nor was any professional guideline definition provided to support the suggestion that pain must occur simultaneously in both legs. The Tribunal accepted that whilst there must be pain in both legs it need not be simultaneous.

127. Dr I gave evidence that bilateral leg pain was a red flag for the consideration for cauda equina syndrome at the time of the consultation. He relied on his own expertise as well as the NICE guidelines.

128. Whilst there had been some issue that Dr I could have been referring to the incorrect guidelines when he compiled his report as the NICE guidelines may have been updated. The Tribunal also noted that Dr I stated that it was his usual practice to check he was using the correct guidelines. The NICE guidelines had been provided to the Tribunal. It was evident from those guidelines that the update to include bilateral leg symptoms as a red flag had been introduced in March 2018.

129. Dr Morlocan was mandated to look at the NICE guidelines. Paragraph 12 of GMP sets out:

> ***12*** *You must keep up to date with, and follow, the law, our guidance and other regulations relevant to your work.*

This includes a requirement to consult NICE guidelines and up to date hospital protocols.

130. Dr Morlocan stated he had not looked at the NICE guidelines but had relied on a Trust Protocol (Protocol 1). This he produced as part of this hearing. It is now agreed that was not the relevant and up to date Protocol for the consultation date. The relevant Trust Protocol was ratified on 28 October 2020 (Protocol 2), Protocol 1, approved in March 2019, did not have the red flags relating to bilateral leg pain. Protocol 2 stated that cauda equina syndrome should be considered:

> *'Lower back pain and* ***Any leg pain*** *or neurological symptoms'*
> [Tribunal's emphasis]

131. Dr Morlocan gave evidence that he did not look at Protocol 2.

132. The NICE guidelines in relation to bilateral leg pain state:

> *'Serious conditions with signs and symptoms that may overlap with sciatica include:*
> - *Cauda equina syndrome. Red flags include:*
>  - *Bilateral sciatica'*

133. In contradiction to the guidelines, Dr Morlocan's relevant notes read: *'no red flags'*, and as a differential diagnosis he recorded *'muscular pain – sciatica'*.

134. The Tribunal accepted the evidence of Dr I, that if one of the red flags for cauda equina syndrome was present there would be a need to proceed *'rapidly'* to an MRI to avoid serious complications and referral for specialist assessment would be required. There was evidently a need for these referrals, given the serious risk to patient safety.

135. The Tribunal was satisfied on all of the evidence that Patient D did not receive good clinical care, as there was clear evidence that she was suffering from bilateral leg pain and the applicable NICE guidelines state that bilateral sciatica or leg pain is a red flag signal for

possible cauda equina syndrome and would therefore require Patient D to have an urgent MRI scan and special assessment.

136. Therefore, the Tribunal found paragraphs 6.a, b and c of the Allegation proved.

## The Tribunal's Overall Determination on the Facts

137. The Tribunal has determined the facts as follows:

Patient A

1. You consulted with Patient A and did not provide good clinical care in that:

    a. on 28 July 2018, you failed to:

        i. obtain an adequate history;
        **Not proved**

        ii. carry out an adequate assessment;
        **Not proved**

        iii. in diagnosing sciatica, rule out significant alternative differential diagnoses;
        **Not proved**

        iv. make an adequate record of the consultation;
        **Determined and found proved**

        v. (in the alternative to paragraph 1.a.i-1.a.iii) record carrying out the actions described in paragraph:

            1. 1.a.i;
            **Determined and found proved**

            2. 1.a.ii;
            **Determined and found proved**

            3. 1.a.iii;
            **Determined and found proved**

b. on 29 July 2018 you prescribed diazepam, as set out in Schedule 1, at too high a dose;
**Admitted and found proved**

c. on 31 July 2018, you:

i. failed to:

1. obtain an adequate history;
**Not proved**

2. carry out an adequate assessment;
**Not proved**

3. in diagnosing sciatica, rule out significant alternative differential diagnoses;
**Not proved**

4. make an adequate record of the consultation;
**Determined and found proved**

5. record that:

a. you had prescribed Tramadol;
**Determined and found proved**

b. Patient A had discharged himself against medical advice;
**Determined and found proved**

c. you had discussed with Patient A the safety of driving home after taking morphine;
**Determined and found proved**

ii. inappropriately prescribed fentanyl patches ('the Prescription') as set out in Schedule 1:

1. at too high a dose for an opiate naïve patient;
**Determined and found proved**

2. when not clinically indicated for acute pain.
   Determined and found proved

iii. failed to provide adequate safety netting advice in respect of the Prescription;
   Determined and found proved

iv. (in the alternative to paragraphs 1.c.i.1 to 1.c.i.3 and 1.c.iii) failed to record taking the actions described in:

1. paragraph 1.c.i.1;
   Determined and found proved

2. paragraph 1.c.i.2;
   Determined and found proved

3. paragraph 1.c.i.3;
   Determined and found proved

4. paragraph 1.c.iii.
   Not proved

2. On 31 July 2018 you inappropriately paid for the Prescription.
   Admitted and found proved

Making a false statement to an inquest

3. Between 28 January 2019 and 11 February 2022, in the course of providing written and/or oral evidence to the inquest into Patient A's death, you falsely stated that:

a. you had no further contact with Patient A's family after you met with Ms C on 7 August 2018;
   Not proved

b. Patient A told you that he was taking Tramadol;
   Not proved

c. Patient A told you that he had previously used fentanyl patches.
   Not proved

4. You knew when you made the statement described at:

    a. paragraph 3.a, that you had continued to exchange messages with Ms C via WhatsApp during August 2018 and September 2018;
    Not proved

    b. paragraph 3.b, that:

        i. Patient A had not told you he was taking Tramadol;
        Not proved

        ii. a false claim that Patient A was taking Tramadol supported your decision to prescribe stronger pain relief;
        Not proved

    c. paragraph 3.c that:

        i. Patient A had not told you that he had previously used fentanyl patches;
        Not proved

        ii. a false claim that Patient A had previously used fentanyl patches supported your purported belief that he was not 'opiate naïve'.
        Not proved

5. Your actions at:

    a. paragraph 3.a were dishonest by reason of paragraph 4.a;
    Not proved

    b. paragraph 3.b were dishonest by reason of paragraph 4.b;
    Not proved

    c. paragraph 3.c were dishonest by reason of paragraph 4.c.
    Not proved

<u>Patient D</u>

6. On 24 May 2021 you consulted with Patient D and did not provide good clinical care in that in the presence of bilateral leg symptoms you failed to:

a. consider possible cauda equina syndrome;
**Determined and found proved**

b. arrange for Patient D to have an urgent MRI scan of her spine;
**Determined and found proved**

c. refer Patient D for specialist assessment.
**Determined and 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 -** 31/07/2024

138. The Tribunal now must decide in accordance with Rule 17(2)(l) of the Rules whether, based on the facts which it has found proved as set out before, Dr Morlocan's fitness to practise is impaired by reason of his misconduct.

## The Evidence

139. The Tribunal has considered all the evidence received during the facts stage of the hearing, both oral and documentary. No further evidence was adduced at this stage of the proceedings.

## Submissions

140. On behalf of the GMC, Mr Brook reminded the Tribunal of its findings at the facts stage and bought the Tribunal's attention to the BNF guidance for information on prescribing and administering opioid patches. Mr Brook's reminded the Tribunal of its finding that Dr Morlocan had not provided good clinical care to Patient A because he had inappropriately prescribed Fentanyl patches at too high a dose.

141. Mr Brook reminded the Tribunal that misconduct is qualified in two respects. It is first qualified by the word professional, which links misconduct to the profession of medicine. Secondly it is measured by the word serious which linked the misconduct to the profession of medicine. Mr Brook suggested that if it were suggested the improper prescription of Fentanyl was a single act, a single act or omission can be misconduct if particularly grave. Mr Brook

submitted prescribing a drug the potency of Fentanyl linked with a lack of safety netting advice is particularly grave and does amount to serious misconduct.

142. Mr Brook submitted that the over prescription of diazepam was serious but not as serious as the overdose of Fentanyl. There was evidence Patient A had previously been prescribed diazepam but not recently.

143. He submitted that safety netting advice might have been given but the Tribunal had found that to be inadequate in the context of prescribing strong opiates. It was inadequate to leave a patient to read and understand a prescription leaflet. The fact that Dr Morlocan had paid for the prescription so it might be collected out of hours also meant there was a lost opportunity for safety netting advice from the pharmacist or any doctor.

144. Regarding the clinical failures found regarding Patient D, Mr Brook noted the Tribunal had found failure to follow GMP which mandated Dr Morlocan to have regard to guidelines and protocols in place at the time, in particular, the NICE guidelines. Mr Brook reminded the Tribunal that Dr Morlocan had said he had not even looked at the NICE Guidelines. He had looked at an out of date Trust Protocol 1. He had put Patient D as risk of serious harm.

145. He submitted in all the circumstances that this amounted to misconduct which is serious.

146. Mr Brook accepted that the Tribunal may find failures in note taking would not amount to serious misconduct by themselves.

147. Mr Brook then made submissions regarding impairment. He referred the Tribunal to *Dame Janet Smith's test in The Fifth Shipman Report, cited in CHRE v NMC and P Grant [2011] EWHC 927 (Admin*). Mr Brooks submitted upholding confidence in the professions must be given significant weight, even where a practitioner has apparently remedied any defective practice or failings.

148. Mr Brook accepted that Dr Morlocan had done a significant amount of CPD. However, Mr Brook submitted the misconduct is serious and a finding of impairment is necessary to uphold standards in this case.

149. On behalf of Dr Morlocan, Ms Tanchel agreed with the GMC's submissions overall as to the relevant legal principles to be applied. However, she submitted that Dr Morlocan's fitness to practice would need be considered 'deplorable' by other practitioners to amount to serious misconduct. Ms Tanchel submitted that committees should put matters into the overall factual context when considering if the misconduct was serious.

150. Ms Tanchel submitted that the Tribunal should approach misconduct in respect initially of each of the allegations found proven individually, and, she submitted, it was not open to a tribunal to make a global finding.

151. She submitted that the Tribunal should consider the context of the case reminding the Tribunal that the Patient attended A and E in the small hours of the morning, this was the context of the consultations and the note taking.

152. Ms Tanchel accepted, in respect of the prescription of diazepam, the prescription of Fentanyl and the finding by this Tribunal of the failure to give adequate safety netting advice on the facts do amount to serious misconduct.

153. With regard to the prescription of diazepam, Ms Tanchel submitted, Dr Morlocan made a clinical decision on the symptoms before him which he now, albeit with the benefit of hindsight, realises was the wrong decision. She submitted this is a classic example of a single incident which does not cross the threshold of serious misconduct.

154. Ms Tanchel submitted that in respect of the Fentanyl and diazepam, 6 years have passed since the misconduct. She referred to the S*hipman* report. She accepted that a present finding of impairment can be founded on past matters. Ms Tanchel referred to *Cohen*, in which Mr Justice Silver stated that it must be highly relevant in determining if doctor's fitness to practise is impaired, that his or her conduct which led to the charges easily is remediable second that it has been remedied.

155. Ms Tanchel submitted that Dr Morlocan has made efforts to remediate his conduct regarding the opiates. She reminded the Tribunal of the e-learning Dr Morlocan had undertaken several courses on opioids, local anaesthetics, antidepressants, multimodal analgesia and the like opioids and end of life, pelvic pain, visceral pain, central and widespread pain, complex regional pain syndrome. She noted there had been no repetition. She reminded the Tribunal of the testimonial evidence from clinicians and submitted it is noteworthy that none expresses concern about damage to the reputation of the profession.

156. She noted Dr Morlocan recorded his reflections on consultations that he was undertaking during his work, which gave him an opportunity to consider no doubt, whether the care he provided was appropriate.

157. By way of overview, Ms Tanchel submitted that Dr Morlocan's fitness to practice is not currently impaired. He has remained employed throughout, demonstrated that the events that took place both in 2018 and 2021 are not at all likely to reoccur. She submitted

there is no patient safety issue. In respect of the reputation of the profession and upholding standards of the profession she submitted that the standard of the profession is not one of perfection.

## Relevant Legal Principles

158. 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.

159. In approaching the decision, the Tribunal was mindful of the two stage process to be adopted. Firstly, whether the facts as found proved amounted to misconduct. Secondly, the Tribunal must determine whether Dr Morlocan's fitness to practise is impaired today, considering Dr Morlocan's misconduct 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.

## Making adequate records

160. The Tribunal noted that Dr Morlocan's failure to make an accurate record of the consultation was seriously below the expected standard, as stated in the expert report of Dr I.

161. The Tribunal considered that Dr Morlocan failed to comply with Good Medical Practice in respect of this paragraph. The Tribunal accepted at the time of events it was busy and, on one occasion, in the early hours of the morning in A & E.

162. The Tribunal is no doubt that Dr Morlocan's failure to produce adequate recordkeeping in respect of Patient A was in breach of paragraph 21 of GMP and the GMC's guidance document and thereby amounted to serious misconduct.

163. The Tribunal noted that the purpose of record keeping is to inform fellow clinicians as to what has or has not happened at a consultation rather than rely on memory which is not reliable. The Tribunal found Dr Morlocan's record could not be relied upon to evidence the consultations in any meaningful way.

164. The Tribunal were of the view this was serious misconduct.

Prescription of Diazepam at too higher dose

165. The Tribunal noted Dr Morlocan from the outset had admitted the dose prescribed by him was too high. The Tribunal had regard to the unchallenged expert report of Dr I in regards to diazepam, in which he sets out the dose of diazepam was three times over the recommended dose.

*'' Dr Morlocan supplied a prescription for 5 days of 10mg diazepam tablets to be taken 3 times a day. Diazepam is a benzodiazepine. It is not indicated for abdominal pain. It may have been given for ongoing back and leg pain. The normal dose of diazepam administered in the emergency department for back pain associated with muscle spasm is 2mg or 5mg. A starting dose of 10mg three times a day for 5 days is too large a dose for muscle spasm and carries the potential for adverse effects including drowsiness and decreased respiration.''*

166. The Tribunal noted Dr Morlocan's explanation that he accepted the dose was too high but that the dose was patient led, as the patient had said he had taken it before and needed a higher dose for his pain. This was in the absence of any medical records. The patient was elderly.

167. The Tribunal considered the prescription of this amount of diazepam was seriously below the standard expected and amounted to serious misconduct.

Inappropriate prescription of Fentanyl patches

168. The Tribunal noted it was not disputed that Dr Morlocan had prescribed roughly 4 times the BNF recommend dose of Fentanyl. The Tribunal also noted Mr J's expert evidence:

*'Having decided to prescribe Fentanyl patches Dr Morlocan disregarded the dosage guidelines in the BNF of 12mcg/hr every 72 hrs and wrote a prescription for just over 4 times that dosage. There was no documented reasoning for this in the A&E record and no evidence from that record regarding any safety advice that was given'*

169. The Tribunal had regard to its findings in it's previous facts determination that Fentanyl was not clinically indicated for acute pain.

170. Although Dr Morlocan, in his statement to the GMC, had suggested that it was Dr F, the consultant in charge of the shift, who had given him the dose to prescribe he now stated

that he did not now have a clear recollection of how he calculated the dose for the Fentanyl prescription. Dr Morlocan accepted that he was the only person responsible for the prescription dose.

171. The Tribunal was mindful of Mr J's evidence that the appropriate dosage guideline in the BNF for an adult, irrespective of whether they were opiate naïve or not, was 12mcg/hr every 72 hours. Dr Morlocan prescribed 50mcg/hr every 72 hours, which was over four times the recommended dose. The Tribunal has already noted that it may be inferred that either Dr Morlocan had either not properly read or not understood the BNF guidelines.

172. The Tribunal determined that Dr Morlocan had not provided good clinical care to Patient A because he had inappropriately prescribed Fentanyl patches at too high a dose for Patient A, an opiate naïve Patient and when it was not clinically indicated.

173. The Tribunal had regard to the expert report and the number of possible side effects,

*'' Fentanyl has a number of side effects including respiratory depression and reduced conscious level. Its prescription was therefore potentially harmful to Patient A.''*

174. The Tribunal also noted that it was agreed that, even when a patient has used opiates before, they can become opiate naïve. It was evident that the tolerance or otherwise to opiates was vital knowledge when deciding if a drug should be prescribed and if so, in what dosage.

175. The Tribunal took into account paragraph 9 of the GMC guidance *Good practice in prescribing and managing medicines and devices* (2013 version) ('the Prescribing Guidance'):

> *9 You must be familiar with the guidance in the British National Formulary (BNF) and British National Formulary for Children (BNFC), which contain essential information to help you prescribe, monitor, supply, and administer medicines.*

176. The Tribunal considered this conduct more serious due to the patient being elderly and potentially more vulnerable. Dr Morlocan admitted in evidence that he was not aware that a patient who had a previous history of taking opiates could become opiate naïve.

177. The Tribunal considered the prescription of this amount of Fentanyl was not clinically indicated and seriously below the standard expected thereby amounted to serious misconduct.

## Failure to provide adequate safety netting advice

178. The Tribunal considered failure to provide adequate safety netting advice as misconduct and whether it amounted to serious misconduct. The Tribunal accepted that when Patient A's wife collected the prescription it would have been accompanied by an explanatory leaflet which she was told to read by Dr Morlocan.

179. The Tribunal had regard to its findings on fact in relation to safety netting advice,

*'Dr Morlocan did not see Patient A's wife when the Prescription was collected by her later in the day on 31 July 2018. He therefore did not speak to her or Patient A again at the hospital to explain the prescription leaflet contents, which the Tribunal accepts was both technical and lengthy.*

*The Tribunal considered that Patient A had been prescribed an extremely potent opiate. Dr Morlocan believed that Patient A was already prescribed tramadol, another opiate. Dr Morlocan had also prescribed him four tablets until he collected his prescription. The Tribunal considered that this was an elderly patient where care had to be taken to ensure the prescription and administration of the same was properly understood. When asked about his approach when he gave evidence Dr Morlocan noted that there was no issue with Patient A's ability to read or his capacity. The Tribunal considered that it was inadequate.'*

180. The Tribunal determined more safety netting advice was needed than telling Patient A and his wife to read the leaflet. The Tribunal noted by not doing more put the patient's safety at risk.

181. The Tribunal determined the failure to provide adequate safety netting advice in the context of a strong opiate, given at such a high dose, was seriously below the standard expected and thereby amounted to serious misconduct.

## Paying for Patient A's prescription

182. The Tribunal accepted the GMC's submission that, whilst it was not Dr Morlocan's intention, by paying for the prescription it resulted in a missed opportunity for safety netting advice from Dr Morlocan or the pharmacist.

183. The Tribunal considered that paying for a patient's prescription is inappropriate and does amount to misconduct. It considered that the act itself is not serious but must be considered in the context of too high of dose of Fentanyl. None the less the Tribunal did not find that this aspect of the misconduct was serious.

Patient D, failure to provide good clinical care

Paragraphs 6.a, b and c

184. The Tribunal was satisfied on all of the evidence that Patient D did not receive good clinical care, as there was clear evidence that she was suffering from bilateral leg pain and the applicable NICE guidelines state that bilateral sciatica is a red flag signal for possible cauda equina syndrome and would therefore require Patient D to have an urgent MRI scan and special assessment.

185. Dr Morlocan was mandated to look at the NICE guidelines. Paragraph 12 of GMP sets out:

> *12 You must keep up to date with, and follow, the law, our guidance and other regulations relevant to your work.*

This includes a requirement to consult NICE guidelines and up to date hospital protocols.

186. The Tribunal had regard to the expert report of Dr I,

*''Bilateral leg symptoms in these situations are a well recognised red flag for possible cauda equina syndrome. This is clearly documented in NICE guidelines. I would expect a reasonably competent speciality doctor in Emergency Medicine to be aware of this and to be aware that referral for a specialist assessment and/ or an MRI scan was indicated urgently.*

*The failure to recognise this as a red flag symptom was seriously below the standard expected of a reasonably competent speciality doctor in Emergency Medicine.*

*This was seriously below as it potentially led to a delay in the diagnosis and treatment of Patient 's cauda equina syndrome.''*

187. The Tribunal had regard to its findings on fact and reminded itself that Dr Morlocan had not kept up to date with his own Trust Guidelines, failed to follow the Trust guidelines, and had not consulted the NICE guidelines at all. This had meant he failed to spot the red flags all set out clearly in those guidelines. In failing to do so he had put patient safety at risk.

188. The Tribunal found these failings fell far below professional standards. Accordingly, it found Dr Morlocan's treatment of Patient D thereby amounted to serious misconduct.

## Impairment

189. The Tribunal having found that the facts found proved amounted to misconduct, went on to consider whether, as a result of that misconduct, Dr Morlocan's fitness to practise is currently impaired.

190. The Tribunal has borne in mind the GMC's over-arching statutory objective in Section 1 of the Medical Act 1983, as amended, which states:

> *"(1A) The over-arching objective of the General Medical Council in exercising their functions is the protection of the public.*
>
> *(1B) The pursuit by the General Medical Council of their over-arching objective involves the pursuit of the following objectives –*
>
> *a) to protect, promote and maintain the health, safety and well-being of the public,*
> *b) 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*
> *c) to promote and maintain proper professional standards and conduct for members of that profession."*

191. The Tribunal also had regard to paragraph 76 of the judgment in the *Grant* case, in which Mrs Justice Cox set out the helpful and comprehensive approach of Dame Janet Smith in her 5th Shipman Report to determining issues of impairment. At paragraph 25.67 of the Shipman Report, Dame Janet identified the following as an appropriate test for panels considering impairment of a doctor's fitness to practise.

> *"Do our findings of fact in respect of the doctor's misconduct…show that his/her fitness to practise is impaired in the sense that s/he:*
> *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 brought 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."*

192. In determining whether Dr Morlocan's fitness to practise is currently impaired by reason of misconduct, the Tribunal considered the whole of the evidence before it, including that given at Stage 1 of the proceedings.

193. The Tribunal found it serious that Dr Morlocan did not consult BNF when checking the appropriate dose. There was no real reason given by Dr Morlocan for the prescription of the dose four times above the recommended limit. Extra care must be taken especially when prescribing a powerful opiate in A and E. The patient went home and so was not the subject of medical supervision at all.

194. The Tribunal went on to consider remediation and the risk of repetition. The Tribunal noted it was 6 years since the misconduct relating to Patient A. Dr Morlocan has been supported to continue working by the Trust.

195. The Tribunal noted Dr Morlocan has engaged with remedial work and participated in CPD coursework. Some of this work was targeted at and the prescription of drugs. The Tribunal considered his remedial work could have been more extensive but accepted Dr Morlocan would have gained insight and had been remediated by these efforts. Dr Morlocan will have also been able to reflect from his participation in the inquest into the death of Patient A and these proceedings.

196. With regards to Patient D, the Tribunal accepted Dr Morlocan's reflective case studies. The Tribunal noted the case study reflection regarding presenting red flags for Cauda Equina Syndrome demonstrated that Dr Morlocan had reflected and updated his knowledge and he continues to apply this to his clinical practice.

197. However, the Tribunal had regard to the fact that Dr Morlocan had previously disregarded BNF guidelines with regard to Patient A. He failed to consult or consulted the wrong guidelines with regard to Patient D. The Tribunal found by not consulting the NICE guidelines and or the up to date Trust correct protocols Dr Morlocan had again put patient safety at risk.

198. The Tribunal accepted there was little or no risk of the misconduct repeating itself given the passage of time, the lack of repetition since the incident relating to Patient D and the evidence presented of remediation and reflection.

### Note taking

199. The Tribunal accepted that Dr Morlocan's note taking had vastly improved.

200. The Tribunal noted with regard to notetaking Dr Morlocan had fully reflected, completed sufficient remediation work through courses. It noted a marked improvement on his note taking. It noted 5 months of having his records checked by Trust "action plans" where he has met standards.

201. However, the Tribunal cannot ignore the inevitable adverse impact on public confidence in Dr Morlocan and the profession as a whole as a consequence of the misconduct relating to both Patient A and Patient D.

202. The Tribunal considered that the need to uphold professional standards and public confidence in the medical profession would indeed be seriously undermined if a finding of current impairment were not made in the circumstances of this case.

203. Accordingly, the Tribunal found that Dr Morlocan's fitness to practice is currently impaired.

### Determination on Sanction - 02/08/2024

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

### The Evidence

205. The Tribunal has considered evidence received during the earlier stages of the hearing where relevant to reaching a decision on sanction. No further evidence was adduced at this stage of proceedings.

## Submissions

206. On behalf of the GMC, Mr Brook acknowledged that the decision as to the appropriate sanction was a matter for the Tribunal's judgement alone. He submitted that the Tibunal may find that the appropriate sanction on the facts is one of suspension. Mr Brook referred to the relevant paragraphs of the Sanctions Guidance (February 2024) (the 'SG'), NICE, British National Formulary (BNF) guidleines and the Tribunal's determination on impairment.

207. Mr Brook in particular, drew the Tribunal's attention to the following paragraphs of the SG:

> *'91 Suspension has a deterrent effect and can be used to send out a signal to the doctor, the profession and public about what is regarded as behaviour unbefitting a registered doctor. Suspension from the medical register also has a punitive effect, in that it prevents the doctor from practising (and therefore from earning a living as a doctor) during the suspension, although this is not its intention.*
>
> 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 (i.e. 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).*
>
> *93 Suspension may be appropriate, for example, where there may have been acknowledgement of fault and where the tribunal is satisfied that the behaviour or incident is unlikely to be repeated. The tribunal may wish to see evidence that the doctor has taken steps to mitigate their actions.*
> …
> *97 Some or all of the following factors being present (this list is not exhaustive) would indicate suspension may be appropriate.*
>
> *a A serious breach of Good medical practice, but where the doctor's misconduct is not fundamentally incompatible with their continued registration, therefore complete removal from the medical register would not be in the public interest. However, the breach is serious*

*enough that any sanction lower than a suspension would not be sufficient to protect the public or maintain confidence in doctors.*

…

*e* *No evidence that demonstrates remediation is unlikely to be successful, e.g. 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."*

208. Mr Brook submitted a sanction of erasure would not be proportionate and would not be in the public interest. However, the Tribunal had found serious clinical errors and several breaches of guidelines of GMP.

209. Mr Brook submitted that the misconduct was so serious that any sanction lower than suspension would not be sufficient to protect the public or maintain confidence in doctors and uphold standards.

210. On behalf of Dr Morlocan, Ms Tanchel noted that the determination of impairment has been made based on public interest alone. She stated that this made submissions in respect of imposing conditions difficult, as conditions are typically imposed when the issues identified by the Tribunal relate more to public safety than to public interest.

211. Ms Tanchel reminded the Tribunal that they must start with the least restrictive sanction and work upwards until the most appropriate and proportionate sanction was imposed.

212. Ms Tanchel invited the Tribunal to have regard to paragraph 68, 69 and 70 of the SG, which relates to taking no action,

*'68 Where a doctor's fitness to practise is impaired, it will usually be necessary to take action to protect the public (see paragraphs 14–16). But there may be exceptional circumstances to justify a tribunal taking no action.*

*69 To find that a doctor's fitness to practise is impaired, the tribunal will have taken account of the doctor's level of insight and any remediation, and therefore these mitigating factors are unlikely on their own to justify a tribunal taking no action.*

*70 Exceptional circumstances are unusual, special or uncommon, so such cases are likely to be very rare. The tribunal's determination must fully and clearly explain:*

*a what the exceptional circumstances are*
*b why the circumstances are exceptional*
*c how the exceptional circumstances justify taking no further action.'*

213. Ms Tanchel accepted that 'no action" cases are very rare. She submitted that the facts in Dr Morlocan's case are exceptional and justify taking no further action. She submitted that there was a range of facts that could amount to exceptional circumstances.

214. Ms Tanchel pointed out that the doctor has worked continually since 2018. She reminded the Tribunal that there was an investigation at the Trust into the prescription of Fentanyl, amongst other issues. The Trust considered the position and determined that it was content for Dr Morlocan to remain in employment.

215. Ms Tanchel reminded the Tribunal that it followed that the Trust had no concerns for patient safety nor for the reputation of the Trust by him continuing to work. Dr Morlocan continued to work at the Trust unrestricted and six years have passed since the incident with Fentanyl.

216. Ms Tanchel submitted that if Dr Morlocan were to be suspended for a period, there is a very real risk he will lose his job at the Trust. Although later said this was based only on the fears expressed by Dr Morlocan rather than any evidence from the Trust that his employment was at risk. She said that Dr Morlocan has worked without complaint since 2018, the Trust itself has investigated the Allegation before the Tribunal. She conceded a delay in proceedings is frequent at the GMC but is more typical for cases where these is criminal proceedings. She accepted that the GMC had to wait for the Coronial Inquiry to be completed.

217. Ms Tanchel then invited the Tribunal to consider the mitigating factors in this case. She submitted Dr Morlocan understands the issue, has insight and has made attempts to remediate. She reminded the Tribunal that Dr Morlocan is adhering to principles of GMP and has many positive testimonials. Dr Morlocan accepts he should have behaved differently and made steps as early as 2021 to make remediate and that his insight has been an ongoing process.

218. Ms Tanchel invited the Tribunal to consider the case of *R (Walker) v Secretary of State for Justice (2017) EWHC 109 Admin,* which directs the Tribunal, when weighing public interest it is also right to consider the impact of a sanction which might deprive the profession of a good clinician. She submitted Dr Morlocan has been otherwise a good clinician and takes good care of his patients.

219. Ms Tanchel accepted the principle set out in the case of *Bolton v The Law Society [1993] EWCA Civ 32 (06 December 1993) 16 [...]The reputation of the profession is more important than the fortunes of any individual member. Membership of a profession brings many benefits, but that is a part of the price.'*

220. Ms Tanchel submitted, the public interest in retaining a doctor, who is aiming to make a valuable contribution to a profession, can be a factor carrying substantial weight against prohibiting him or her from working in that profession. The public would also be served by Dr Morlocan being able to continue to care for patients.

221. Ms Tanchel submitted, if suspended, Dr Morlocan faces a disproportionate outcome, namely the possibility of losing his job, where the finding of impairment was made solely on public interest grounds as opposed to any ongoing risk to patient safety. She submitted the public interest was already satisfied from the finding of impairment.

## The Tribunal's Determination on Sanction

222. The Tribunal reminded itself that the decision as to the appropriate sanction to impose, if any, was a matter for it alone, exercising its own judgement. In reaching its decision on sanction, the Tribunal had regard to the SG, its findings on the facts, its determination on misconduct and impairment and the submissions made by Mr Brook and Ms Tanchel.

223. It bore in mind that the purpose of a sanction is not to be punitive, but to protect patients and the wider public interest, although it recognised that any sanction imposed may have a punitive effect. It reminded itself that in deciding what sanction, if any, to impose, it should start with the least restrictive.

224. Throughout its deliberations, the Tribunal applied the principle of proportionality, balancing Dr Morlocan's interests with the public interest whilst at the same time recognising what was said in *Bolton v. Law Society* [1994] 1 WLR 512, namely that the reputation of the profession concerned is more important than the fortunes of any individual member.

225. The Tribunal also had regard to the GMC's over-arching objective in section 1(1A) of the Medical Act 1983, sub-sections (b) and (c) in section 1(1B) 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.

## Aggravating and Mitigating Factors

226. The Tribunal has already set out its decision on the facts and impairment which it considered during its deliberations on sanction. Before deciding what action, if any, to take in respect of Dr Morlocan's registration, the Tribunal took into account and balanced the aggravating and mitigating factors in this case.

227. The Tribunal identified a number of aggravating factors. The Tribunal determined there had been a serious breach of several paragraphs of GMP, namely, 8, 11, 12, 16. The Tribunal noted there had been 2 separate incidents of misconduct. The first incident in 2018 which involved an elderly patient, who might be considered more vulnerable due to his age. Dr Morlocan had failed to consult or disregarded BNF guidelines as to the appropriate dose of Fentanyl, a very strong opiate. He had prescribed 4 times the BNF recommended dose to Patient A. He had given inadequate safety netting advice. He had also prescribed 3 times the recommended dose of diazepam to the same patient.

228. The second incident in 2021 involved a patient whose symptoms presented with ongoing leg pain. Dr Morlocan had similarly failed to consult appropriate guidance. He had not consulted up to date Trust guidance for a patient presenting with leg pain. He had not consulted NICE guidelines, as he was mandated to do. Consequently, he had failed to recognise a 'red flag' signal for Cauda Equina Syndrome. He failed to refer Patient D for an urgent MRI or specialist treatment.

229. Both incidents demonstrated seriously below standards of clinical care and patient safety being put at risk. The Tribunal also noted that in both incidents Dr Morlocan failed to consult or follow guidelines, the fundamental purpose of which is protect patient safety.

230. The Tribunal identified a number of mitigating factors. The Tribunal accepted that there was no misconduct prior to 2018. It considered the passage of time to be a mitigating factor, it noted there had been 6 years since the 2018 incident and 3 years since the 2021 incident, during which time there has been no repetition, although the fact that there had been two incidents made this mitigation less powerful.

231. The Tribunal had regard to the many positive testimonials about Dr Morlocan. It noted the Testimonials are extensive and comprehensive and show an otherwise high standard of care.

232. The Tribunal had regard to the evidence of insight and remediation supported by case study reflections and CPD work completed by Dr Morlocan. The Tribunal noted, in oral evidence at this tribunal, Dr Morlocan admitted he did not refer to NICE guidelines and now has taken responsibility for his failings. It noted that Dr Morlocan accepted sole responsibility for the incorrect doses prescribed.

233. The Tribunal noted Dr Morlocan took part in a programme implemented by the Trust post the incidents to ensure that he could return to safe practice. The Tribunal had noted

that Dr Morlocan has undertaken a reflective practice log showing a willingness to learn from his failings and seeking to ensure they do not repeat themselves. The Tribunal noted there has been no repetition since 2021 and that Dr Morlocan has been in continuous practise.

234. Considering the mitigating and aggravating factors. The Tribunal proceeded in its deliberations on what the appropriate and proportionate sanction to impose would be, if any. The Tribunal considered each sanction in ascending order of severity, starting with the least restrictive.

## No action

235. The Tribunal first considered whether to conclude the case by taking no action. It accepted that taking no action following a finding of impaired fitness to practise would only be appropriate in exceptional circumstances.

236. The Tribunal had regard to Ms Tanchel's submissions in respect of taking no action. The Tribunal considered the 'exceptional' factors identified by Ms Tanchel. First it was suggested that Dr Morlocan might lose his employment, Secondly, that this was a finding on public interest grounds only. Thirdly, that there had been a delay in reaching these proceedings. Fourthly, that Dr Morlocan has been investigated by is Trust and has continued to work for them in the intervening time.

237. The Tribunal noted that no evidence had been provided to suggest that Dr Morlocan's employment is at risk. The Tribunal noted that the findings or views of the Trust were not before this Tribunal and considered that they were not relevant to the Tribunals considerations as to sanction.

238. The Tribunal has already determined that this misconduct was serious and would have an obvious adverse impact on public confidence in Dr Morlocan and the medical profession as a whole. The Tribunal noted that public confidence in the profession is more important than an individual doctor. The Tribunal saw nothing unusual in the time taken to reach this hearing, particularly bearing in mind there had been an inquest into the death of Patient A.

239. The Tribunal determined that there are no exceptional circumstances in this case and that, given the seriousness of its findings, it would not be sufficient, proportionate, or in the public interest to conclude this case by taking no action.

## Conditions

240. The Tribunal next considered whether to impose conditions on Dr Morlocan's registration. The Tribunal noted that conditions have not been suggested by either party to be an appropriate sanction.

241. The Tribunal determined that, conditions would not be an appropriate sanction in this case, nor would they sufficiently mark the seriousness of Dr Morlocan's misconduct.

## Suspension

242. The Tribunal went on to consider whether to impose a period of suspension on Dr Morlocan's registration. The Tribunal accepted that suspension does have a deterrent effect and could be used to send a signal to Dr Morlocan, the profession, and the public about what is regarded as behaviour unbefitting a registered doctor.

243. The Tribunal acknowledged the SG provides that suspension may be appropriate where there is an acknowledgement of fault and it is satisfied the misconduct is unlikely to be repeated.

244. The Tribunal considered paragraphs 91, 92 and 93 of the SG to be relevant to its consideration of suspension:

> *'91 Suspension has a deterrent effect and can be used to send out a signal to the doctor, the profession and public about what is regarded as behaviour unbefitting a registered doctor. Suspension from the medical register also has a punitive effect, in that it prevents the doctor from practising (and therefore from earning a living as a doctor) during the suspension, although this is not its intention.*
>
> *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 (i.e. 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).*
>
> *93 Suspension may be appropriate, for example, where there may have been acknowledgement of fault and where the tribunal is satisfied that the behaviour or*

*incident is unlikely to be repeated. The tribunal may wish to see evidence that the doctor has taken steps to mitigate their actions. '*

245. The Tribunal was satisfied that Dr Morlocan had acknowledged fault. He has demonstrated sufficient insight into the impact his misconduct had upon patient safety. He has sought to learn and implemented his learning to his practice. The Tribunal has determined it was unlikely that there was any risk of future repetition. This was due to all the evidence it had heard regarding his otherwise good standard of care, the passage of time and the evidence of reflection and remediation that has been presented at this hearing.

246. The Tribunal was of the view that it had found that Dr Morlocan's actions amounted to several serious breaches of GMP which had led to serious failings in the standard of clinical care provided by him. Patient safety, on more than one occasion, was put at risk.

247. Taking all the evidence, submissions and its own deliberations into account, the Tribunal was satisfied that a period of suspension would mark the seriousness of Dr Morlocan's misconduct.

## Erasure

248. The Tribunal considered the sanction of erasure. As has been already noted there have been significant departures from GMP and there has been consequent risk to patient safety regarding both Patient A and Patient D. This was a very serious misconduct that raised notable public confidence concerns.

249.The Tribunal had regard to paragraph 109(b) of the SG:

*109 Any of the following factors being present may indicate erasure is appropriate (this list is not exhaustive).*

..

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

250. Having noted this was serious misconduct which involved 2 distinct incidents. Dr Morlocan is held in otherwise high regard. He had remained in continuous practice. Since the misconduct Dr Morlocan had worked to develop insight. He has reflected and

remediated. The Tribunal has already determined it unlikely that the misconduct would be repeated.

251. Having balanced all the factors in this case, including the aggravating and mitigating factors, Dr Morlocan's insight, the remedial steps taken and the low risk of repetition the Tribunal considered that erasure would be disproportionate in the circumstances.

## Length of suspension

252. The Tribunal considered Dr Morlocan's misconduct reflected very serious failings by him, failings which fall far below the expected standards of a competent doctor.

253. As has been previously rehearsed, there have been distinct episodes where Dr Morlocan has not provided good clinical care to 2 patients in 2018 and 2021.
In 2018 he had failed in his duties to consult BNF guidance regarding the correct dose of Fentanyl, a very strong opiate, to prescribe to an elderly patient which led to him prescribe 4 times the recommended dose. He prescribed 3 times the recommended dose of diazepam to the same patient. He had failed to provide sufficient safety netting advice when issuing the prescription for Fentanyl. He had put that patient at risk of harm.

254. In 2021, 3 years later in a consultation, where a patient presented with leg pain, he had failed to consult the most up to date Trust protocol. He failed to consult the NICE Guidelines at all. This meant Dr Morlocan missed a red flag signal for Cauda Equina Syndrome. He failed to refer the patient for an urgent MRI scan as recommended in both guidelines. This put this patients safety potentially at risk.

255. As the Tribunal has noted these are very serious failings and fall far below the standards expected of a competent medical practitioner and must be marked with a suspension that reflects those serious failings and their impact on public confidence.

256. The Tribunal reminded itself that confidence in medical profession as a whole is more important than the individual doctor. The Tribunal accepted that this period of suspension will be punitive, but it is not intended to be. It is only intended to mark the seriousness of the misconduct and to be of such length so as to maintain public confidence and uphold professional standards. The length of the suspension takes into account the public interest in returning Dr Morlocan to practise as soon as is appropriate on the facts of this case.

257. The Tribunal determined to suspend Dr Morlocan's registration from the medical register for a period of 7 months. It was satisfied that such a period marked the seriousness of Dr Morlocan's misconduct and upheld the over-arching objective to maintain public confidence in the profession and uphold proper professional standards. The Tribunal concluded that a suspension of this length would provide Dr Morlocan with an opportunity to develop insight into the impact his misconduct had on public confidence in him and the medical profession as a whole.

258. The Tribunal determined to direct a review of Dr Morlocan case. A review hearing will convene shortly before the end of the period of suspension. The Tribunal wishes to clarify that at the review hearing, the onus will be on Dr Morlocan to demonstrate how he has developed insight into the impact his misconduct had on public confidence in the profession and that he has maintained his knowledge and skills.

## Determination on Immediate Order - 02/08/2024

259. Having directed that Dr Morlocan's registration be suspended for seven months, the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether Dr Morlocan's registration should be subject to an immediate order.

## Submissions

260. On behalf of the GMC, Mr Brook submitted that it not necessary in this case to make an immediate order in light of the Tribunals findings. He submitted that there is no risk to patient safety.

261. On behalf of Dr Morlocan, Ms Tanchel submitted that an immediate order is not necessary in this case in light of the Tribunal's findings that there is no risk to patient safety.

## The Tribunal's Determination

262. The decision whether to impose an immediate order or not was a matter for the Tribunals discretion based on all of the facts. The Tribunal has considered the relevant paragraphs of the SG which state:

*'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….'*

*173 An immediate order might be particularly appropriate in cases where the doctor poses a risk to patient safety. For example, where they have provided poor clinical care or abused a doctor's special position of trust, or 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*.

263. The Tribunal noted that there were very serious clinical failings in this case and a suspension of some length has been imposed. However, the Tribunal noted that Dr Morlocan had remained in continuous practice throughout the events that concerned the Tribunal. There were no current patient safety concerns, nor were there likely to be in the future.

264. The issue was solely one of public confidence in Dr Morlocan and consequently the medical profession as a whole, given the seriousness of the clinical failings. The Tribunal were of the view that the wider public interest will be served by the substantive suspension that has been imposed.

265. The Tribunal concluded; therefore, it is not necessary to impose an immediate order to protect members of the public, it is not in the public interest, and it is not in the best interests of the doctor.

266. This means that Dr Morlocan's registration will be suspended 28 days from the date on which written notification of this decision is deemed to have been served unless he lodges an appeal. If Dr Morlocan does lodge an appeal, he will remain free to practise unrestricted until the outcome of any appeal is known.

267.That concludes the case.

ANNEX A – 13/06/2024

## Application in respect of NICE Guidelines

1. Prior to Mr Brook closing the case presented on behalf of the GMC, he invited the Tribunal to consider the NICE Guidelines relating to "red flag" symptoms for possible cauda equina syndrome.

## Submissions

2. Mr Brook submitted that the NICE Guidelines had already been exhibited to the expert report of Dr I dated 20 November 2022 by way of embedded hyperlink. He submitted that if the Tribunal did not accept that the NICE Guidelines were already in evidence, they could be fairly admitted into evidence pursuant to Rule 34(1) of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules').

3. Ms Tanchel submitted that the NICE Guidelines were not already in evidence. She submitted that to have properly exhibited them, they should have been produced by Dr I's report as a separate appendix. She submitted it could not be fair to admit them at this stage of proceedings and, in addition, this could lead to further enquiry being required.

## The Relevant Legal Principles

4. The Tribunal had regard to Rule 34(1) of the Rules:

> '*The Committee or a Tribunal may admit any evidence they consider fair and relevant to the case before them, whether or not such evidence would be admissible in a court of law.'*

## The Tribunal's Decision

5. The Tribunal was satisfied that Dr I had exhibited the NICE Guidelines in his report dated 20 November 2022. The Tribunal drew no distinction between there being an embedded hyperlink and the Guidelines appearing in an appendix to the report. They were clearly relied upon by Dr I when forming his opinion.

6. The Tribunal was of the view that the NICE Guidelines are relevant to the issue as whether the symptom of bilateral leg pain was a red flag for cauda equina syndrome at the time of the consultation (paragraph 6 of the Allegation).

7. Furthermore, Dr I had been cross-examined on behalf of Dr Morlocan as to whether he had referred to the correct NICE Guidelines that had been in force at the time of the consultation with Patient D on 24 May 2021, leading to a potential unfairness to Dr Morlocan if this issue could not be resolved and the correct Guidelines produced.

8. The Tribunal was of the view that it would be grossly unfair to Dr Morlocan if the Tribunal was to rely on guidelines that were not relevant at the date of the consultation. It would also be unfair to the GMC to leave an impression that incorrect guidelines might be relied upon by the Tribunal.

9. In the alternative, if the Tribunal is incorrect about the NICE Guidelines already being an exhibit in evidence, for all the reasons already set out, it determined that the admission of the NICE Guidelines as evidence that should be introduced under Rule 34(1) of the Rules to be crucial to fairness on both sides arising as rebuttal evidence or new evidence.

10. Therefore, the Tribunal granted the application made by Mr Brook on behalf of the GMC to produce the relevant NICE Guidelines.

ANNEX B – 18/06/2024

Application under Rule 17(2)(g)

1. At the close of the GMC's case, Ms Tanchel, on behalf of Dr Morlocan, made an application under Rule 17(2)(g) of the Rules that there was no case to answer in respect of a number of paragraphs of the Allegation.

2. Ms Tanchel's application concerned the following paragraphs of the Allegation:

Patient A

1. You consulted with Patient A and did not provide good clinical care in that:

a. on 28 July 2018, you failed to:

i. obtain an adequate history;

ii. carry out an adequate assessment;

iii. in diagnosing sciatica, rule out significant alternative differential diagnoses;

[…]

c. on 31 July 2018, you:

i. failed to:

1. obtain an adequate history;

2. carry out an adequate assessment;

3. in diagnosing sciatica, rule out significant alternative differential diagnoses;

[…]

ii. inappropriately prescribed fentanyl patches ('the Prescription') as set out in Schedule 1:

1. at too high a dose for an opiate naïve patient;

2. when not clinically indicated for acute pain.

iii. failed to provide adequate safety netting advice in respect of the Prescription;

[…]

<u>Making a false statement to an inquest</u>

3. Between 28 January 2019 and 11 February 2022, in the course of providing written and/or oral evidence to the inquest into Patient A's death, you falsely stated that:

a. you had no further contact with Patient A's family after you met with Ms C on 7 August 2018;

b. Patient A told you that he was taking Tramadol;

c. Patient A told you that he had previously used fentanyl patches.

4. You knew when you made the statement described at:

a. paragraph 3.a, that you had continued to exchange messages with Ms C via WhatsApp during August 2018 and September 2018;

b. paragraph 3.b, that:

i. Patient A had not told you he was taking Tramadol;

ii. a false claim that Patient A was taking Tramadol supported your decision to prescribe stronger pain relief;

c. paragraph 3.c that:

i. Patient A had not told you that he had previously used fentanyl patches;

ii. a false claim that Patient A had previously used fentanyl patches supported your purported belief that he was not 'opiate naïve'.

5. Your actions at:

a. paragraph 3.a were dishonest by reason of paragraph 4.a;

b. paragraph 3.b were dishonest by reason of paragraph 4.b;

c. paragraph 3.c were dishonest by reason of paragraph 4.c.

<u>Patient D</u>

6. On 24 May 2021 you consulted with Patient D and did not provide good clinical care in that in the presence of bilateral leg symptoms you failed to:

a. consider possible cauda equina syndrome;

b. arrange for Patient D to have an urgent MRI scan of her spine;

c. refer Patient D for specialist assessment.

## Submissions

On behalf of Dr Morlocan

3. Ms Tanchel reminded the Tribunal that Dr Morlocan is required to prove nothing and that the burden of proof remains with the GMC. She referred the Tribunal to the relevant legal principles and the test to be applied from the case of *R v Galbraith* [1981] 73 Cr App R 124 ('*Galbraith*'). In *Galbraith*, Lord Lane LCJ said:

> *'How then should the judge approach a submission of 'no case'? (1) If there is no evidence that the crime alleged has been committed by the defendant, there is no difficulty. The judge will of course stop the case. (2) The difficulty arises where there is some evidence but it is of a tenuous character, for example, because of inherent weakness or vagueness or because it is inconsistent with other evidence. (a) Where the judge comes to the conclusion that the prosecution evidence, taken at its highest, is such that a jury properly directed could not properly convict upon it, it is his duty, upon a submission being made, to stop the case. (b) Where however the prosecution evidence is such that its strength or weakness depends on the view to be taken of a witness' reliability, or other matters which are generally speaking within the province of the jury and where on one possible view of the facts there is evidence upon which a jury could properly come to the conclusion that the defendant is guilty, then the judge should allow the matter to be tried by the jury.'*

4. Ms Tanchel made submissions in respect of paragraphs 1ai-iii, 1ci1-3, 1cii1 and 2, 1ciii and 3, 4, 5 and 6 of the Allegation. They are summarised below.

5. Ms Tanchel submitted that the GMC's case was entirely predicated on its experts' analysis of the clinical records relating to Patient A. Ms Tanchel submitted that both experts, Dr I and Mr J's, had taken the documents provided to them as being demonstrative without challenge. Ms Tanchel was critical of the experts for making findings of facts and for not consistently considering alternative findings.

6. In respect of paragraph 1.a of the Allegation, Ms Tanchel submitted that the GMC had advanced no evidence beyond the clinical records about what occurred in the consultations

Patient A had when he attended A&E on 28 July 2018. Further, as Dr F agreed in his evidence, patients can tell different clinicians' different things. Ms Tanchel submitted that it was open to the Tribunal to infer that an adequate history was taken and an adequate assessment of Patient A performed because it was clear from the clinical records that investigations were requested and undertaken, and medication was prescribed.

7. In respect of paragraph 1.c of the Allegation, Ms Tanchel referred the Tribunal to her earlier submissions. She submitted that her submission in respect of paragraph 1.c of the Allegation was further fortified by the additional investigations that were undertaken when Patient A attended A&E again on 29 July 2018, for which there are no clinical records.

8. In respect of paragraph 1.c.ii.2 of the Allegation, Ms Tanchel submitted that the expert evidence of Mr J was clear, that the nature of Patient A's pain being chronic or acute was *'blurred'* and therefore there was no evidence to support a referral for acute pain.

9. Ms Tanchel reminded the Tribunal that the GMC's case relied on the absence of relevant clinical notes and the expert opinion of Dr I. She criticised Dr I's evidence and submitted that his objectivity had been compromised.

10. She further submitted that the Tribunal could not be sure of the applicable NICE guidance at the time of the consultation. Nor which guidance Dr I had looked at when he compiled his report. She submitted there was other material he ought to have asked for. In absence of that material, he formed opinions without all the evidence.

11. For each consultation Ms Tanchel pointed out that there was no direct evidence by any witness of what was said or discussed in the consultations save for that given by Dr Morlocan.

12. As regards the difference between the triage notes, Dr F's notes and the memory of Dr Morlocan, Patient A may have said different things to different clinicians. Further, she submitted, as opposed to being dishonest, even if there was a discussion about tramadol, may Dr Morlocan have misunderstood it?

13. She noted that the GMC relied on the note taken by Dr F, and Dr F's evidence at the Coroner's Court as to the meaning of *'previously taken tramadol'* as concluding he was no longer taking tramadol. There was no time period as to when *'previously'* might have been. She submitted Dr F's note was open to other interpretations supportive of current use. She

submitted that Dr F had no proper or clear recollection of his own consultation and the meaning of *'previously taken'*.

14. Ms Tanchel submitted there was insufficient evidence, under the second limb of *Galbraith*, to safely support the contention this was not asserted by Patient A.

15. Ms Tanchel submitted that there was no evidence of clinical failings. Investigations were requested by Dr Morlocan and medication was prescribed. That supports the proposition that a history was taken and an assessment was made by him.

16. With regard to paragraph 3 of the Allegation, making false statements to an inquest, Ms Tanchel made submissions on each sub-paragraph. With regard to paragraph 3.a and the assertion of *'no further contact'* with Patient A's family post 7 August 2018, Ms Tanchel pointed to the passage of time, it was 18 months after the meeting on 7 August 2018 that Dr Morlocan had made his statement for the Coroner. She further, relied on the fact that Dr Morlocan did not have the WhatsApp messages at the time he made his Coroner's statement. She submitted that even if statements were made by Dr Morlocan to the Coroner that turned out not be correct, then a reasonably directed Tribunal could not conclude they were dishonest statements when fading memory might be the more likely reason.

17. With regard to paragraphs 3.b and 3.c she accepted there were differences in the clinical notes regarding tramadol and that there was no clinical record of Patient A ever being prescribed fentanyl. She submitted, that if Dr Morlocan got those things wrong, it does not follow that he lied about them.

18. It is evident from the GP records that there have been prescriptions for opiates in the past and use of patches to administer pain relief medication by Patient A (not fentanyl). If Dr Morlocan misunderstood at the time, it follows that he can't have been dishonest to the Coroner.

19. Ms Tanchel reminded the Tribunal that allegations of dishonesty were serious. The Tribunal should be careful before inferring dishonesty where there may be other explanations for the conduct alleged. In order to consider dishonesty, she submitted the Tribunal must decide if there is sufficient evidence that those matters were not canvassed with Patient A at the time of the consultation.

20. She submitted that a properly advised Tribunal considering the test of dishonesty and all other reasonable explanations could not be satisfied that Dr Morlocan had been dishonest.

21. In respect of Patient D, as set out in paragraph 6 of the Allegation, Ms Tanchel submitted that there was insufficient evidence of bilateral leg pain or that of what guidelines were relevant at the time. It was not clear that bilateral leg pain was a red flag for cauda equina syndrome. It was not clear what guidelines Dr I had consulted when compiling his report. She accepted there was a query of the date of the Trust Guidance but pointed to the evidence of Dr I which agreed it was reasonable for Dr Morlocan to rely on his Trust Guidance.

On behalf of the GMC

22. On behalf of the GMC, Mr Brook submitted that in relation to the paragraphs of the Allegation that Dr Morlocan failed to provide good clinical care there was an adverse inference that may be drawn from the absence of a clinical note to reflect those actions. He submitted a reasonable Tribunal could conclude that Dr Morlocan had not done any of the things that he now purported to have done.

23. Mr Brook submitted that clinical notes were the most important record of what did or did not happen in any consultation. Mr Brook accepted that they were not in themselves conclusive and all the circumstances and facts must be considered by the Tribunal. He reminded the Tribunal of Dr Morlocan's duties set out in Good Medical Practice regarding note taking. These duties being especially important where investigations are ordered or medicines are prescribed.

24. Mr Brook asked the Tribunal to compare the note taking with regard to Patient A's consultations with the more extensive notes taken by Dr Morlocan for Patient D.

25. Mr Brook submitted there was no reason to conclude the experts had been anything other than objective and professional with their duties to the Tribunal. They had acted on instructions. Where the experts had been given more information, they had fairly considered whether to revise their opinions.

26. Mr Brook submitted there was sufficient evidence that Dr Morlocan had inappropriately prescribed fentanyl patches at too high a dose for an opiate naive patient as this was a potent drug where care had to be taken before it was prescribed and in what dose.

There was nothing in Patient A's GP records, the triage notes nor in Dr F's notes to support the assertion that Patient A had ever been prescribed fentanyl. The evidence in the GP notes was that tramadol was last prescribed in 2014-2015. There was no evidence that Patient A would have built up a tolerance to opiates on the face of all the medical records to justify the high dose prescribed by Dr Morlocan.

27. Mr Brook made the same submission about the importance of noting the clinical reasons for prescribing fentanyl. Mr Brook accepted that a patient could suffer from chronic pain and incur episodes of acute pain but submitted that the relevant presenting picture was one of acute pain. He pointed to Dr Morlocan's clinical note which described *'acute back pain'*. He pointed to the relevant Trust Guidance dated July 2017, which states: *'DO NOT prescribed* [sic] *transdermal opioid patches for patients with acute pain. See trust guidance for information on prescribing and administering opioid patches'*.

28. He submitted there was sufficient evidence for the Tribunal to conclude the prescription for fentanyl was not clinically indicated.

29. Mr Brook submitted there was also sufficient evidence to support the allegation that Dr Morlocan had failed to provide safety netting advice for the fentanyl prescription as per paragraph 1(c)(iii) of the Allegation. He pointed out that there was no record of safety netting advice in his Dr Morlocan's consultation notes for the 31 July 2018 at all.

30. Mr Brook accepted that the prescription is accompanied by a leaflet but even if Patient A was told to read it carefully, he reminded the Tribunal of the evidence that these are long and technical documents that require clinical explanation. Again, he submitted this was a strong opiate to prescribe and needed careful safety netting advice that should have been noted.

31. Mr Brook submitted that there was sufficient evidence to support that Dr Morlocan had made a false statement to the Tribunal as per allegations paragraphs 3.a-c and had done so knowing those statements were untrue as per paragraphs 4.a-c.

32. Mr Brook reminded the Tribunal there were phone calls and WhatsApp messages over a number of days with Ms C, following a face to face meeting on 7 August 2018. These messages were about the progress of the inquest for Patient A's death. Dr Morlocan must have known that he sent and received messages even if he no longer had them at the time he made his witness statement. It was submitted that a reasonable Tribunal could safely conclude that he had made a false statement to the Coroner. Mr Brook conceded the issue of

contact was not covered in the oral evidence given to the Coroner so the GMC did not pursue that part of the allegation.

33. Mr Brook also submitted that there was sufficient evidence to support the case, at this stage, that Dr Morlocan had made false statements knowing them to be untrue when he said Patient A told him he was taking tramadol and had previously taken fentanyl. He reminded the Tribunal that there was nothing in the GP records to suggest tramadol has been prescribed since 2014-15. There was no evidence of fentanyl being prescribed in any form at any stage. Neither did the triage notes or Dr F's notes support these assertions. Whilst it was accepted that a patient could say different things to different doctors, he submitted that it was also important to note such differences in a consultation note. Dr Morlocan made no such note.

34. As for the suggestion that Patient A may have seen a private doctor, he submitted that this was speculative and little or no weight could be placed on it.

35. By way of overview, he submitted that there was sufficient evidence to support the contention that Dr Morlocan had made false statements to the Coroner to attempt to justify his prescription of fentanyl, especially in such a high dose. He reminded the Tribunal this dose was more than four times the dose recommended by the BNF guidelines for an opiate naive patient.

36. With regard to paragraph 5, the allegations of dishonesty, Mr Brook accepted that cogent evidence was needed to be presented by the GMC. Mr Brook also accepted that it was right for the Tribunal to carefully assess any evidence of other explanations that might fairly be inferred on the facts.

37. Mr Brook submitted that the Tribunal could infer that Dr Morlocan lied to the inquest asserting that Patient A said these things to him, potentially to justify his inappropriate prescribing of fentanyl to Patient A, when the cause of Patient A's death was being investigated.

38. The Tribunal could infer, from all the evidence on this topic presented at paragraph 4 of the Allegation, that he was being dishonest. He submitted that a reasonable Tribunal could safely exclude as less than probable other possible explanations posited.

39. In respect of Patient D, as set out in paragraph 6 of the Allegation, Mr Brook submitted that there was sufficient evidence that Patient D was suffering from bilateral leg

symptoms. This should have led to Dr Morlocan to consider cauda equina syndrome and arrange for an MRI and send Patient D for specialist assessment. He did none of these things.

40. He reminded the Tribunal that Dr Morlocan did not consult the applicable NICE guidelines which contains bilateral leg pain as a red flag for cauda equina syndrome, as was his duty under GMP. Dr I gave evidence about the NICE guidelines and they had now been produced for the Tribunal with the date of the relevant amendment relating to bilateral leg pain being March 2018.

41. He accepted that Dr Morlocan has produced a Trust Protocol which Dr Morlocan states he relied upon at the time. It is not clear if this was the up to date Protocol at the time of the 24 May 2021 consultation. He pointed out that it states at the foot of the document "Approval date: March 19, Reviewed: March 20" He asked the Tribunal to note that this document had only been produced as part of this hearing. No "reviewed" Protocol has been produced. Mr Brooks accepted that Dr I said it would be reasonable for Dr Morlocan to rely on a Trust Protocol but stated he had expressed surprise a 2019 Protocol did not contain the red flag of bilateral leg pain, introduced in 2018 as the NICE guidelines contained the red flag.

42. Mr Brook reminded the Tribunal that Dr Morlocan had a duty, pursuant to his obligations under GMP, to stay up to date with all guidelines including those issued by NICE.

43. Mr Brook submitted that there was sufficient evidence to support allegation 6 that Patient D was suffering from bilateral leg pain and that, in light of the relevant NICE guidelines, Dr Morlocan had failed to do those matters set out at 6.a-c.

## The Relevant Legal Principles

44. The Tribunal had regard to the test in *Galbraith* (as set out above). It also had regard to Rule 17(2)(g) of the Rules:

> *'the practitioner may make submissions as to whether sufficient evidence has been adduced to find some or all of the facts proved and whether the hearing should proceed no further as a result, and the Medical Practitioners Tribunal shall consider any such submissions and announce its decision as to whether they should be upheld'*

45. In respect of the allegations that Dr Morlocan acted dishonestly, the Tribunal bore in mind that it would be required to apply the test laid down by the Supreme Court in *Ivey v Genting Casinos (UK) Ltd* [2017] UKSC 67 *('Ivey')*, namely that the Tribunal should first

ascertain subjectively the actual state of Dr Morlocan's knowledge or belief as to the facts. Whether the belief is reasonable may be a matter of evidence, but reasonableness is not an additional requirement when considering whether the belief was genuinely held. The Tribunal will then ascertain whether his conduct was dishonest applying the objective standards of ordinary decent people.

## The Tribunal's Decision

Paragraphs 1a(i)(ii)(iii) and 1c(i) 1, 2 and 3

46. The Tribunal had regard to Ms Tanchel's submission that the absence of notes relating to obtaining an adequate history, carrying out an adequate assessment, and the ruling out of a significant diagnosis, does not automatically mean that that those actions did not take place. They considered the point made that Dr Morlocan has got to the stage of prescribing which suggested a history must have been taken and/or assessments carried out. They took into account it may be inferred the A&E department would have been busy at the time notes were being made.

47. The Tribunal considered the detail missing from the notes when considering the allegation of failing to take an adequate history on both 28 July 2018 and 31 July 2018. The Tribunal also considered Dr I's report dated 26 August 2022 setting out what he would have expected to be recorded in the circumstances of each consultation.

48. The Tribunal had regard to Dr Morlocan's diagnosis, in which he stated he and Dr F had agreed, on 28 July 2018, that Patient A's pain was likely to have been the result of sciatica. The result of Patient A's consultation with Dr Morlocan was that Dr Morlocan prescribed co-codamol and two lots of Diazepam. On this occasion, there was no discussion relating to Patient A having been prescribed previously tramadol.

49. The Tribunal then considered the 31 July 2018, when the fentanyl was prescribed. This was now the third time Patient A had attended the A&E department. Due to a lack of notes in relation to the visit on 29 July 2018, the Tribunal was unable to ascertain what diagnosis had been made. However, it was clear that investigations had been raised as x-rays had been taken. This demonstrated that it was reasonable to infer that some history was taken and some assessment carried out. The issue for the Tribunal was whether those were *'adequate'*.

50. The Tribunal took into account that no note was made by Dr Morlocan on 31 July 2018 as to the medication Patient A was currently on, or how well it was working.

51. The Tribunal had regard to paragraphs 16 and 21 of *Good medical practice* (2013 edition) ('GMP') which states:

> ***16*** *In providing clinical care you must:*
>
> *a. prescribe drugs or treatment, including repeat prescriptions, only when you have adequate knowledge of the patient's health and are satisfied that the drugs or treatment serve the patient's needs*
>
> *b. provide effective treatments based on the best available evidence*
>
> *c – e not relevant*
>
> *f. check that the care or treatment you provide for each patient is compatible with any other treatments the patient is receiving, including (where possible) self-prescribed over-the-counter medications*
>
> *…*
>
> ***21*** *Clinical records should include:*
>
> *a. relevant clinical findings*
>
> *b. the decisions made and actions agreed, and who is making the decisions and agreeing the actions*
>
> *c. the information given to patients*
>
> *d. any drugs prescribed or other investigation or treatment*
>
> *e. who is making the record and when.*

52. The Tribunal accepted that the absence of any note in Patient A's records on both 28 July 2018 and 31 July 2018 is not conclusive as to what was said or done at the consultation. However, it should be borne in mind that these were important records as to what did, or did not, happen at the consultations. The importance of the records was obvious; a clinician seeing Patient A would need to know what happened at any consultation that preceded their own, to safely manage the patient. The Tribunal also noted that GMP states that recording of this clinical information is a mandatory obligation.

53. The Tribunal considered that it was open to the view that Dr I's opinions were not undermined by the fact he had not been provided with Patient A's GP notes as part of his instructions. He had considered them and not changed his opinions as part of this hearing.

54. The Tribunal looked at the whole of the evidence, including what Dr I said ought to have been included in the notes on both the dates in July 2018. It is accepted by Dr Morlocan that those matters ought properly to have been included in his notes.

55. The Tribunal had in mind that, whilst it was reasonable to infer this is likely to have been a busy A&E department, patient safety is paramount, particularly where the patient is elderly and has been suffering from a number of ongoing medical problems and receiving different treatments and prescriptions. The Tribunal noted that care was required in the taking and noting of his history and which assessments had been carried out, as well as what treatments and drugs Patient A was currently or historically prescribed.

56. There was no record of what, if any, differential diagnosis had been considered before the diagnosis of sciatica was reached. The Tribunal considered that by not noting what alternatives had been considered, any practitioner following up on the care of Patient A would not have known what had been ruled out on both 28 July 2018 and 31 July 2018.

57. The Tribunal accepted Ms Tanchel's observation that there was no other witness to the consultations with Patient A. Sadly, Patient A is deceased and the only other person who may have been at his consultations was his wife. There was no evidence from her. The Tribunal may fairly consider the most important record of what happened in consultation is not witnesses, where memories might be fallible, but the consultation notes themselves.

58. At this stage of proceedings, the Tribunal was satisfied that there was sufficient evidence that a reasonable Tribunal, properly directed, could find the doctor had failed in the ways alleged in paragraphs 1a(i-ii) and 1c(i)1-3.

Paragraph 1c(ii)1

59. The Tribunal had regard to Ms Tanchel's submission that there was insufficient evidence to suggest Patient A was opiate naïve. Dr Morlocan prescribed, using the BNF guidelines, the dosage being described as "in mid-range" of those guidelines.

60. The Tribunal took into consideration the definition of *'opiate naïve'* provided by Mr J in words to the effect of *''someone who is currently not receiving opiates, has not been on*

*opiates for any length of time or not taking opiates on a regular basis".* When asked further about "length of time", Mr J replied in words to the effect of *"not on a regular basis, for example a few weeks".* The Tribunal also noted that it was agreed that, even if a patient has used opiates before, they can become opiate naïve. It was evident that the tolerance or otherwise to opiates was vital knowledge when deciding which drug should be prescribed and in what dosage.

61. The Tribunal must take into account paragraph 9 of the GMC guidance *Good practice in prescribing and managing medicines and devices* (2013 version) ('the Prescribing Guidance'):

> *9 You must be familiar with the guidance in the British National Formulary (BNF) and British National Formulary for Children (BNFC), which contain essential information to help you prescribe, monitor, supply, and administer medicines.*

62. The Tribunal must also have regard to the BNF guidelines. In terms of dosage in circumstances where fentanyl is being used by transdermal application:

> '*Adult*
> *Initially 12 micrograms/hour every 72 hours, when starting, evaluation of the analgesic effect should not be made before the system has been worn for 24 hours (to allow for the gradual increase in plasma-fentanyl concentration)—previous analgesic therapy should be phased out gradually from time of first patch application, dose should be adjusted at 72 hour intervals in steps of 12–25 micrograms/hour if necessary.'*

63. The Tribunal considered what Dr Morlocan prescribed was 50mcg/hour every 72 hours which was more than four times the recommended starting dose for an opiate naïve patient.

64. The Tribunal noted that Dr Morlocan accepted that he did not have Patient A's GP records to know what the documented history of Patient A's use of opiates was. It noted, however, even if he had sight of them, there was no medical record of Patient A ever being prescribed fentanyl.

65. The Tribunal also noted that, there were no suggestion made by Patient A in triage notes or in Dr F's records of fentanyl being prescribed.

66. The Tribunal noted the evidence of Mr E, the pharmacist, who said that he had queried the dose being prescribed with Dr Morlocan but that he had been reassured that it was needed as the patient was in pain, so had not further queried the prescription, as requested by Dr Morlocan.

67. In his evidence to the Coroner, Dr Morlocan had relied upon the assertion of fentanyl use as part of the history he was given by Patient A in the consultation. Dr Morlocan accepted that he did not make a note of this assertion. A reasonable Tribunal may find this surprising, given the fact that this was a very strong opiate being prescribed and by a doctor in A&E where, it was agreed, there was less ability to manage its usage safely once the patient had been discharged.

68. Having regard to all the available evidence, including Dr Morlocan's consultation notes, the Tribunal concluded that a reasonable and properly directed Tribunal could find paragraph 1c(ii)1 proved.

Paragraph 1c(ii)2

69. The Tribunal bore in mind Ms Tanchel's submission, that due to the *'blurred'* picture of chronic and acute pain, there was insufficient evidence that fentanyl should not have been prescribed. The NICE guideline is to not prescribe fentanyl for acute pain, they do not preclude a prescription for chronic pain.

70. Mr J gave evidence of the difference between chronic and acute namely that acute pain comes *'out of the blue'* suddenly either on day of presentation or shortly before. He gave examples that it might be pain resulting from minor surgical procedures or trauma. In contrast, chronic pain is persistent over some time. He explained that the timescale varies in different patients. Pain may start as acute and then become chronic in nature as it persists. Pain may fluctuate or vary in intensity. He stated a patient can have acute and chronic pain at the same time. There was broad agreement about these definitions between the parties.

71. Dr I noted in his expert report:

> *'The records made by Dr Morlocan during this attendance are very brief.*
>
> *He has recorded the presence of back pain and that the patient had fallen 2 week prior to this. Also that he had pain in his left leg. He has recorded a diagnosis of acute back pain and spasm'.*

72. Dr I then went on to list the information he would have expected Dr Morlocan to have recorded.

73. The Tribunal agreed that it could be reasonably inferred from this consultation record the nature of the pain Patient A was suffering from was acute. On the face of his own consultation notes, Dr Morlocan had recorded a diagnosis of *'acute'* pain and back spasm.

74. The Tribunal had regard to the '*Guidelines for adult acute pain management'* 2017 Trust guidelines, in which it states:

> *'DO NOT prescribed* [sic] *transdermal opioid patches for patients with acute pain. See trust guidance for information on prescribing and administering opioid patches'*

75. Whilst a reasonable Tribunal could accept that there was a mixed or blurred picture of chronic and acute pain, the reason for Patient A's attendance at A&E could be concluded as acute. It could be inferred that Dr Morlocan was indicating the correct nature of Patient A's pain when describing it as acute.

76. The Tribunal was satisfied that a reasonable and properly directed Tribunal could conclude that Dr Morlocan prescribed fentanyl patches inappropriately when they were not clinically indicated for acute pain.

Paragraph 1c(iii)

77. The Tribunal took into account that Dr Morlocan could have given safety netting advice but made no record of the same. The Tribunal considered that the safety netting advice was set out in the leaflet that came with the prescription of fentanyl, when it was dispensed.

78. The Tribunal must take into account paragraph 21 of GMP which states:

> *21 Clinical records should include:*
>
> *a. relevant clinical findings*
>
> *b. the decisions made and actions agreed, and who is making the decisions and agreeing the actions*

*c. the information given to patients*

*d. any drugs prescribed or other investigation or treatment*

*e. who is making the record and when.*

79. The Tribunal must have regard to the fact that GMP, therefore, mandates doctors to make a record of the information given to patients.

80. The Tribunal considered Mr J's expert report in which he states:

*'There is a lack of documented assessment of patient 's pain, no documented discussion or thoughts around decision making in the prescribing of the Fentanyl patches and no note regarding safety netting or monitoring of the response to the use of such patches.*
*…*
*Having decided to prescribe Fentanyl patches Dr Morlocan disregarded the dosage guidelines in the BNF of 12mcg/hr every 72 hrs and wrote a prescription for just over 4 times that dosage. There was no documented reasoning for this in the A&E record and no evidence from that record regarding any safety advice that was given.'*

81. The Tribunal noted that Dr Morlocan did not see Patient A or his wife when the prescription was collected so, therefore, cannot have spoken with them at that time to explain the prescription leaflet contents, which a reasonable Tribunal might conclude was both technical and lengthy.

82. The Tribunal concluded there was sufficient evidence that a reasonable and properly directed Tribunal could conclude that Dr Morlocan failed to provide adequate safety netting advice in respect of the prescription.

Paragraph 3a

83. The Tribunal noted that Dr Morlocan accepted that further contact had been made with Patient A's family after his meeting with Ms C on 7 August 2018. The Tribunal noted the GMC's concession that these particulars were not explored in oral evidence at the Coroner's hearing and therefore only the documentary evidence of the Coroner's statement is relied upon.

84. The Tribunal must consider other inferences for example, one inference for the assertion of *'no contact'* may be of the passage of time, Dr Morlocan may have forgotten about this contact as opposed to making a false statement to the Coroner.

85. In assessing the likelihood or otherwise of Dr Morlocan lapse of memory, the Tribunal noted that after the meeting on 7 August 2018, there were a number of texts and WhatsApp messages exchanged between Dr Morlocan and Ms C between 10 August and 19 September inclusive, approximating 12 messages.

86. The Tribunal noted that the contact was evidently about the inquest and therefore an important subject, it was reasonably something that a doctor in the circumstances was likely to remember. This was particularly as it might be described to be unusual for a doctor to be in contact directly with a patient or a patient's family outside usual Trust investigation protocols. This reasonably lent support to the GMC's case that contact of this sort was more likely to be remembered, even given the passage of time.

87. The Tribunal was of the view that whilst there may well be other explanations for his failure to tell the coroner about contact after 7 August 2018 the Tribunal was satisfied that there was sufficient evidence for a reasonable and properly directed Tribunal to conclude that it was more likely that Dr Morlocan had made a false statement to the inquest.

Paragraphs 3b and 3c

88. The Tribunal had regard to Dr Morlocan's evidence to the Coroner in which he stated Patient A had told him he was taking tramadol. Regarding a lack of contemporaneous notes to validate this, Dr Morlocan told the Coroner:

> *'One of the issues that arises is I had issues with recording the real-time recommendations, so what I tended to do is focus on the patient's needs and then when I had time like half an hour, time to spare, I will write everything down, but in this case the only thing we've done is discussed and managed and then write my diagnosis and signed I think it.'*

89. The Tribunal took into consideration that there was no record in the GP notes that Patient A had taken tramadol since 2014-2015. The records also evidenced that fentanyl had never been prescribed, although Buprenorphine was prescribed in patch form in 2015. There was no evidence of private prescriptions before the Tribunal.

90. Whilst it was not clear whether Dr Morlocan would have had access to the GP notes at the time of the relevant consultations, if he had he will have detected the inconsistency between that and the history he states was given to him by Patient A.

91. The Tribunal had regard to the fact that the triage notes, the list of current medication and Dr F's notes do not include any suggestion of being prescribed tramadol or fentanyl. Dr Morlocan, in his evidence to the Coroner, said he was told by Patient A that he was currently using tramadol and had previously used fentanyl patches. Dr Morlocan accepted this assertion was inconsistent with the history taken by his fellow medical practitioners and he also accepted, in his evidence to the Coroner, that he had not noted the patient's assertions in his own consultation notes nor raised the inconsistency with Patient A.

92. In all the circumstances, this Tribunal was satisfied that a reasonable and properly directed Tribunal could come to the conclusion that Dr Morlocan had made false statements to the Coroner, in relation to these particulars of the paragraphs 3b and c of the allegation.

Paragraph 4a

93. The Tribunal was of the view a reasonable Tribunal, for all the reasons set out in relation to paragraph 3a above, could be satisfied Dr Morlocan knew, when asserting there was no further contact, he was making a false statement.

Paragraphs 4b(i),(ii), 4c(i) and (ii)

94. A reasonable Tribunal could be of the view that one reason for making a false claim that Patient A was currently prescribed tramadol and making a false claim that he had previously been prescribed fentanyl was to support Dr Morlocan's decision to prescribe fentanyl patches. Such a prescription should only be issued by a practitioner with accurate knowledge and comprehensive knowledge of a patient's history including medication.

95. If it was accepted, for the reasons already set out, that Patient A had not told Dr Morlocan he was currently taking tramadol nor had he stated that he had been previously prescribed fentanyl, a reasonable and properly directed Tribunal could fairly infer that Dr Morlocan knew he had made those false statements to explain the prescription of fentanyl and at such high dose.

Paragraph 5a, b and c

96. The Tribunal accepted that dishonesty must be proved by the GMC. The Tribunal accepted this was to be done by reasonable inferences only being drawn from the facts presented. A reasonable Tribunal must discount other equal or more likely inferences that could reasonably be drawn from the same facts.

97. The Tribunal noted that it may be inferred, for example that due to the passage of time, Dr Morlocan may have forgotten his further contact with Patient A's family after the meeting or that there might be confusion with patches used to administer a different drug in the past. This may have caused confusion on the part of the patient or Dr Morlocan. There was nothing in the notes made by Dr Morlocan to assist.

98. Whilst there may be other explanations the Tribunal concluded that a reasonably advised Tribunal, having found that Dr Morlocan gave false statements to an inquest, knowing that statements to be false, could conclude that by both the objective and subjective standards as per *Ivey*, that Dr Morlocan's actions were dishonest.

Paragraph 6a, b and c

99. In assessing whether there was sufficient evidence that Patient D was suffering from bilateral leg symptoms the Tribunal first looked at the clinical notes made on the 24 May 2021.

d) The paramedics noted:

*'…"Patient has been experiencing bilateral sciatica for 4 weeks, she thinks she jarred her back jumping off the side of a boat onto the gangway. Since then the pain radiates from her buttocks down both the backs of her legs. She denies saddle anaesthesia, no loss of bladder/ bowel. Patient has been experiencing weakness in her legs with them giving out approximately 3 times previously with ambulance attending on Sunday but todays has now left patient unable to stand or take any of her own weight…"'*

e) The record was made by triage read: *'GP given various analgesia, no saddle anaesthesia both of sides pain'.*

f) Dr Morlocan in his consultation notes recorded:

*'Patient explained that based on the examination she is having bilateral*

*muscular spasms that give* [illegible word] *shooting pains to legs and that medication she is taking is only putting her to sleep* [illegible words]. *As such I showed a set of exercises that will allow the muscles to relax and minimize the* [illegible word] *of her pain.'*

100. The Tribunal could be satisfied from the medical notes that Patient D had pain in both legs.

101. Arising from questions in cross-examination by the defence, regarding the meaning of bilateral, Dr I gave evidence that *'presence of leg pain does not have to be in both legs at same time. Red flag symptom (in NICE guidelines) is for pain to be suffered in both legs.'* He also said *'I have no doubt that the patient had bilateral leg pain …. I am 100% certain there is no need for the pain to be in both legs simultaneously.'*

102. Dr I gave evidence that Bilateral leg pain was a red flag for the consideration for cauda equina syndrome at the time of the consultation as per the NICE guidelines.

103. The Tribunal considered Ms Tanchel's submission the NICE guidelines looked at by Dr I could have been incorrect guidelines when he compiled his report. The Tribunal also noted that Dr I stated that it was his usual practice to check he was using the correct guidelines. The NICE guidelines were also provided to the Tribunal.

104. The Tribunal noted that these NICE guidelines highlighting the bilateral sciatica red flag were introduced in March 2018, which follows that they were applicable at the relevant time. Dr Morlocan was mandated to look at the NICE guidelines. GMP requires doctors to consult NICE guidelines and up to date hospital protocols.

105. The Tribunal, whilst having been provided with a Trust Protocol, did not know if this was correct at the time of the consultation with Patient D as at the end it states it was approved in March 2019 with a review date of March 2020. This Protocol does not have the red flags relating to bilateral leg pain. The Tribunal considered Ms Tanchel's submission that it was reasonable for Dr Morlocan to follow his own hospital protocol and Dr I acceptance that this would be reasonable.

106. However, the difficulty for the Tribunal, at this stage, was that it did not know whether this was the applicable protocol in May 2021 as there was no evidence as to whether there was a more updated Protocol as might be inferred from the review date of March 2020, more than a year before the relevant consultation.

107. Accordingly, the Tribunal concluded any Tribunal would be cautious about placing weight on a late provided Protocol that may be not the one Dr Morlocan states he relied upon in any event.

108. Dr Morlocan, according to his notes, showed Patient D exercises rather than consider the red flag raised for cauda equina syndrome, this was contrary to the NICE guidelines in relation to bilateral leg pain:

> *'Serious conditions with signs and symptoms that may overlap with sciatica include:*
>
> - *Cauda equina syndrome. Red flags include:*
>   - *Bilateral sciatica*

109. Dr I, in his oral evidence, told the Tribunal that if one of the red flags for cauda equina syndrome was present there would be a need to proceed *'rapidly'* to an MRI to avoid serious complications.

110. The Tribunal was satisfied that a reasonable Tribunal, properly directed, could come to the view that there was sufficient evidence that Patient D did not receive good clinical care, as there sufficient evidence that she was suffering from bilateral leg pain and the applicable NICE guidelines state that bilateral/sciatica or leg pain is a red flag signal for possible cauda equina syndrome and would therefore require Patient D to have an urgent MRI scan and special assessment.

Conclusion

111. The Tribunal refused Ms Tanchel's applications under Rule 17(2)(g) of the Rules.

Schedule 1 – prescribing/ administration of drugs

| | Date | Drug | Dose |
|---|---|---|---|
| 1. | 29/07/2018 | Diazepam | 15 x 10mg tablet (one, 3 times a day) |
| 2. | 31/07/2018 | Matrifen/Fentanyl | 4 x 50µg patch (one every 72 hours) |