Strictly Confidential

External Review Report

The Management of Employment Issues Concerning Dr Salil Mohamed Korambayil

Royal Devon University Healthcare NHS Foundation Trust

Carole Taylor-Brown MSc FCIPD

March 2024

(Amended August 2024)

CONTENTS

		PAGE
1.	BACKGROUND TO THE REVIEW	2 - 5
2.	KEY FINDINGS	6 - 12
3.	CONCLUSIONS & PRINCIPAL RECCOMENDATIONS	13 - 15
4.	APPENDIX 1	16

1 Background to the Review

Organisational Context

1.1 The Royal Devon University Healthcare NHS Foundation Trust (the Trust) was established in April 2022, bringing together the Royal Devon and Exeter NHS Foundation Trust (RD&E) based in Exeter and the Northern Devon Healthcare NHS Trust (NDHT) based in Barnstaple.

1.2 Sam Higginson is the current Chief Executive Officer (CEO), and Dame Shan Morgan is the Chair.

Circumstances Giving Rise to the Review

1.3 Dr Salil Mohamed Korambayil (Dr SK), worked as a trainee surgical doctor (ST4), at NDHT between 02 October 2019 to 06 October 2020.

1.4 On 28 August 2020, two NDHT members of staff independently shared with their managers that they had seen information on a social media (Facebook) post, alleging a serious sexual assault in which Dr SK was seemingly implicated.

1.5 The concerns were escalated to NDHT senior managers one of whom was the Responsible Officer. The three managers, M1, M2 and M3 met with Dr SK to discuss the matter later same day.

1.6 Dr SK denied the allegations and indicated he believed his social media account had been hacked. However, it was agreed that Dr SK should not be at work whilst these matters were considered further.

1.7 *Dr SK was not scheduled to be at work over the bank holiday weekend and was due to take some planned annual leave immediately after the bank holiday, before returning to work on 03 September 2020. A further meeting with him was scheduled for that day.

1.8 Although there was agreement that Dr SK should not be at work, it relied on Dr SK's cooperation and his expected absence due to the bank holiday and his planned leave.

1.9 The rationale supporting the decision that Dr SK should not be at work was not formally recorded, for example in an Exclusion Risk Assessment (ERA) and no safeguarding measures were put in place to ensure that Dr SK did not attend the workplace during that period.

1.10 On 31 August 2020 (Bank Holiday Monday), the Police contacted NDHT and advised that a complaint of a serious sexual assault involving Dr SK had been received and was being investigated.

1.11 M4 spoke with the Police on 01 September 2020 and subsequently met with M1, and M2. After assessing the additional information provided by the Police, they completed a formal ERA for Dr SK, as a result of which, Dr SK was formally excluded from work with effect 03 September 2020 i.e. when he was scheduled to return to work from his annual leave.

1.12 Dr SK's exclusion continued until 06 October 2020, the end date of his rotation with NDHT, after which he was due to move on pre-planned rotation, to Royal Cornwall NHS Trust (RCHT).

1.13 Prior to Dr SK's rotation to RCH, M2 briefed RCHT about the issues concerning Dr SK. RCHT conducted their own assessment of matters and determined that with support Dr SK could continue on his planned rotation with them effective 12 October 2020.

1.14 On 26 October 2020, the Police informed NDHT that they had filed their investigation into the allegations against Dr SK pending any further evidence coming to light.

1.15 On 09 April 2021, RCHT advised NDHT they had suspended Dr SK following an allegation of rape which had been reported to the Police [redacted]. The complainant had also alleged that Dr SK appeared to have inappropriately accessed their medical records.

1.16 Whilst Dr SK was under Police investigation for the alleged rape, RCHT undertook an investigation into Dr SK's alleged breach of their Information Governance Policies and subsequently dismissed Dr SK.

1.17 Separately, the four NHS Trusts where Dr SK had worked on his training rotations, formed a multi-disciplinary group, hosted by Devon and Cornwall Constabulary, to co-ordinate their response to emergent issues surrounding Dr SK. The Care Quality Commission (CQC) and NHS England (NHSE) were invited to join the group.

1.18 In October 2021, NHSE asked the four Trusts and Health Education England (referred to as the Deanery in this report), to undertake an investigation of the onboarding arrangements for Dr SK up to the time of the allegations raised at RCHT, to identify if any 'red flags' had been missed.

1.19 The NDHT investigation completed in May 2022, and identified some areas of learning. These included improving the recording and monitoring of compliance with mandatory training for medical staff, written recording of actions when handling the initial complaint, and a lack of feedback to the staff who had raisied the initial concerns.

1.20 The investigation also identified an apparent acceptance of some inappropriate behaviour by Dr SK amongst some colleagues and seemingly, a lack of awareness of harassment.

1.21 The Police investigation into Dr SK continued and culminated in two separate processes; one to deal with the rape charges and the other the alleged data breaches.

1.22 In November 2023, Dr SK was found guilty of three counts of rape, and at the time of writing this report is awaiting trial for the issues concerning alleged data breaches.

Terms of Reference

1.23 As part of a wider Trust learning process, I have been asked by the Trust to review the Trust's management of Dr SK, using a risk-based, learn and just approach, starting from identification of allegations through to his conviction for rape for which there are five principal phases:

1. The Trust's response to concerns raised relating to allegations on Facebook of sexual assault. (The primary focus in the terms of reference).
2. The Trust's response to the alert from RCH of rape allegations and data breaches.
3. The Trust's response to the Police investigation.
4. The Trust's response to the request from NHSE to undertake an investigation into the onboarding of Dr SK.
5. The Trust's response to court proceedings.

1.24 For the purpose of this report phase two and three have been combined. The full terms of reference are shown at appendix 1.

Conduct of the Investigation

1.25 After a desktop review of the documents supplied to me, I interviewed the colleagues identified in the terms of reference.

1.26 With each interviewee's consent, I recorded interviews and prepared a written record of their interview. Each interviewee was given the opportunity to review the written record before it was finalised. The digital recordings have been destroyed as agreed with interviewees.

1.27 I have collated the interview records and information provided to me by the Trust in a separate evidence bundle which is available to the Trust.

My Report

1.28 My report aims to present a fair and balanced view of the matters I have considered.

1.29 If necessary, when making findings of fact, I have reached a conclusion on the balance of probabilities, i.e., an event or matter is more likely than not.

1.30 The framing of the terms of reference has led to me to identify some potential missed opportunities or gaps in the management of Dr SK's case. I would like to stress my observations are offered to support corporate learning and are based on the evidence shared with me and the scope of the terms of reference.

1.31 Where I have identified a potential missed opportunity or gap it does not necessarily mean that the events that followed could either have been prevented or predicted; there are always opportunities to identify things that could have been done better.

1.32 It is also important to note that when the initial events took place in 2020, it was during an unprecedented period globally and for the NHS because of the Covid pandemic. As a result, a number of restrictions, lockdowns and changes in regular working practices and governance arrangements had taken place.

1.33 For example, in March 2020, the National Medical Director (NMD) proposed some relaxations within the application of professional standards at local level to free up capacity. The NMD's advice included relaxing mandatory training requirements that were not directly relevant to the Covid outbreak and suggesting whilst maintaining oversight of professional standards should be maintained, the focus should be on concerns assessed as high risk. (NHSE Letter, 19 March 2020).

1.34 I consider it is relevant when considering matters four years on, to bring to mind the unusual context that faced people handling matters in 2020.

1.35 I completed and submitted my report in March 2024. In June 2024 I was asked to make amend the report to clarify some points. The clarifications were minor did not alter the substance of my findings.

1.36 I was also asked to amend the job title Chief Medical Officer (CMO) to Executive Medical Director (EMD). For clarity in the evidence base and in particular the interview records the references to CMO (which seemingly was the commonly recognised job title at that time), should be taken to be the same as EMD.

1.37 I am happy to discuss the contents of this report or provide any further clarification that may be required.

*Note: Subsequent to the submission of the final report additional factual information was provided in August 2024 to confirm that Dr SK was not expected at work over the Bank Holiday as a consequence a correction was made to the section above Circumstances leading to the Review and in the findings at 2.4. However, the additional information did not alter the finding that an ERA, should have been completed to record the decision on 28 August 2020 and set how and why, although it had been decided Dr SK should not be at work, he was not formally excluded. It is noted that view is not shared by the individuals involved.

2 Key Findings

The Trust's (NDHT) response to the initial concerns about Dr SK - 2020.

2.1 The initial escalation by staff of their concerns about the social media postings to their managers on **28 August 2020** and their managers' actions in raising this with senior managers the same day was timely and appropriate.

2.2 M1, M2 and M3 responded to the escalation of those concerns promptly, and pragmatically.

2.3 Although no particular NDHT policy was enacted at this stage, the initial actions were broadly consistent with the approach that would normally be followed when a concern about an employee's conduct is raised. They included:

1) Meeting with Dr SK promptly to inform him of the alleged concerns, the intended actions, and giving him the opportunity to comment.

2) Obtaining confirmation in writing from Dr SK that his comments on the alleged concerns had been correctly summarised in a record of the meeting with him.

3) Showing awareness of the potential risks the allegations raised, and taking steps to ensure Dr SK was not present at work whilst further consideration of matters was underway.

4) Contacting the GMC, and the Deanery to alert them to the alleged concerns. (As a trainee doctor, Dr SK's RO was the Post Graduate Dean).

5) Checking the medical records of the person named in the social media posting to establish if the person concerned was or had been patient treated by Dr SK.

6) Ensuring pastoral support was available to Dr SK whilst matters were under consideration.

7) Advising Dr SK to self-refer to the GMC and to contact the Police.

2.4 Given the nature of the allegations those actions could have been strengthened and potential risks mitigated by:

1) Seeking immediate advice from Practitioner Performance (PPA) within NHS Resolution (formerly NCAS).

   The allegations indicated that potentially a criminal offence had been committed and might be a matter for consideration under the Maintaining High Professional Standards (MHPS) Policy. It is advisable when dealing with a potential MHPS matter to refer to the PPA at the earliest opportunity. There is no minimum threshold for seeking PPA advice and in this case, they could have offered an independent perspective on next steps.

2) Undertaking an ERA, to record the decision on 28 August 2020 and set how and why, although it had been decided Dr SK should not be at work, he was not formally excluded.

   (Although it had been agreed that Dr SK should not be at work, it relied on Dr SK's cooperation and no safeguards were enacted to ensure that he did not attend the workplace over that period. If an ERA had been completed it is more likely that it would have encouraged a comprehensive risk assessment whilst also providing a formal record of the considerations supporting the decision reached. That approach is also more likely to have encouraged consideration of what safeguards would be necessary short of formal exclusion, to ensure that Dr SK did not attend the workplace. in that period).

3) Escalating the issue to the NDHT CEO or Executive Director on call on 28 August 2020 for guidance on whether NDHT should report the matter to the Police.

   Notwithstanding Dr SK's denials, the allegations suggested a serious criminal offence might have been committed, and it was NDHT's responsibility to report the allegations to the Police.

4) Recognising that as the matter was in the public domain, there was a risk that the issue could escalate over the Bank Holiday weekend and warranted escalation to the NDHT CEO and/or Executive Director on call.

5) Referring the matter to Safeguarding.

   The social media postings suggested the matters might involve a vulnerable adult which might reasonably have prompted an early discussion with Safeguarding.

6) Ensuring that Dr SK's pastoral support was provided by a person outside of those involved or likely to be involved in the assessment of matters.

   Although it understood this was challenging to organise, this important boundary was not maintained.

7) Advising Dr SK to contact his professional organisation for advice and support.

8) Ensuring that as a matter of good practice, feedback was provided to the staff raising concerns that the matter was being investigated and that they were aware of where they could raise any ongoing concerns they held.

9) Establishing a case file and action log to capture all relevant correspondence, actions taken, and contemporaneous notes.

2.5 Following receipt of the additional Police information on **01 September 2020**, the response by M2, M3 and M4 was prompt, however from my interviews it seems on balance none considered that they had formally invoked the MHPS Policy or were following a particular Policy at this stage as no investigation had been initiated due to the Police investigation.

2.6 The actions taken included:

1) Completion of a formal ERA on 01 September 2020.

2) Escalating the issue to the CEO, NDHT EMD, Director of Operations, and informing the Deanery and GMC of the new information.

3) Meeting with Dr SK on 03 September 2020 to inform him of the decision to exclude him pending the Police investigation.

4) Pro-active provision of Occupational Health support to Dr SK from 03 September 2020.

5) Maintaining contact with Dr SK and continuing to encourage Dr SK to self-refer to the GMC, (however, see also 2.4 – 6 above and 2.7 - 3 below).

6) Briefing and updating RCHT on the situation including sharing the ERA.

7) Keeping in regular contact with the Police.

2.7 Those actions could have been strengthened and potential risks mitigated by:

1) Escalating the matter to PPA for advice.

Given the new information the PPA should have been contacted consistent with the first stages of the MHPS Policy.

2) Ensuring a Non-Executive Director (NED) was appointed to oversee the case once the decision to formally exclude Dr SK had been taken on 01 September 2020.

Although a MHPS investigation had not been initiated, there was a potential for this to follow and as a formal exclusion had been instigated the action was within scope of the first stages of the NDHT MHPS Policy (section 4.3).

3) Ensuring the individuals overseeing the case did not become involved in providing ongoing pastoral support to Dr SK, advocating on behalf of Dr SK, or seeking informal professional advice on behalf of Dr SK.

It seems that with best intent, this boundary was not maintained, and that could have or be seen to have, potentially conflicted the parties involved and potentially compromised objectivity.

4) Referring the matter to Safeguarding.

The information provided by the Police confirmed the complainant was a vulnerable adult and that another reportedly vulnerable female had told them that Dr SK had befriended her and had a sexual relationship with her. That information should have prompted a substantive contact with Safeguarding.

5) Conducting a further and wider review of the named complainant's medical records using an appropriate person who had not been involved to that point, to assure that nothing had been missed on the initial check.

The first check was limited, and in light of the new information and disparity in Dr SK's accounts of events, a wider check using an independent person, to identify if any other contact between Dr SK and the patient had occurred should have been initiated.

6) Discussing with the EMD Dr SK's lack of transparency and honesty in his account of matters.

Dr SK gave varying accounts on the matters raised with him and although it seems he was a very plausible individual his conduct was inconsistent with the requirements of GMC's Good Medical Practice code. That inconsistency should have prompted a discussion with the EMD and Deanery RO to determine and agree what if any next steps should follow and where that responsibility lay.

7) Reviewing with the EMD whether on the balance of the above, if a wider check should be made of Dr SK's clinical activities at NDHT to assure that there were no apparent variations in his practice.

8) Completing and submitting a written report summarising the events, actions taken and outcomes to the EMD, Deanery and RCHT (including a copy of the ERA).

The Trust's response to the alert from RCHT & the Police investigation.

2.8 The initial response to the notification by RCHT was dealt with by the colleagues involved in the issues in 2020. From the information I received, it does not appear the concerns reported by RCHT were immediately escalated within the Trust to the CEO.

2.9 Ideally, this matter should have been escalated promptly to the CEO and the EMD before any action was taken by the team at NDHT.

2.10 The Trust's response following the internal escalation was comprehensive and well considered. The actions taken included:

1) Establishing a multidisciplinary approach with Executive oversight.

The decision to allocate the Director of Governance the lead role in co-ordinating matters was pivotal in enabling corporate oversight, broader and objective consideration of the risks; in ensuring timely reporting to the appropriate bodies, and enhanced communication with the Police, NHSE, and the other Trusts.

2) Proactively contacting the Police and establishing a multidisciplinary group drawing in the other Trusts where Dr SK had worked.

   This was a critical intervention by Director of Governance which supported shared learning and response within the NHS family and examples best practice.

3) The Trust's arrangements in contacting the patients (and staff), potentially affected by the alleged data breaches and in establishing the helpline was well organised, carefully considered and demonstrated a proper response by the Trust to the Duty of Candour.

4) The support to the staff handling the helpline calls was well organised and included a post event de-brief and the option to access counselling and the approach examples best practice.

5) Similarly, the co-ordinated daily debriefs and ongoing liaison with the Police whilst the helpline was in place was exemplary.

2.11 Some areas for future consideration are:

1) Providing specialist training to staff who are required to deal with distressing information which might be outside their normal range of experience before their exposure to the content.

   This was an exceptional matter, and the content of the calls was not something that the call handlers were likely to have experienced before. If similar exceptional events occur, this might be a useful and positive intervention.

2) Having an agreed position and clarity about how and what the internal briefing arrangements should be put into on place.

   Managing the balance of confidentiality and keeping people who need or should know informed internally is always a challenge. It appears there was good communication from the working group and by the Director of Governance to the CEO, however, it is less clear how that information was shared with executives and the Board. I was advised that the Board received verbal updates whilst the Chairs of the joint Governance Committee were briefed in more detail. Once there was clarity about the scheduling of the court case, the Director of Governance prepared a full briefing for the Board (document dated October 2023), and I understand there have been subsequent updates to the Board.

3) This case has highlighted the risk of clinical staff inappropriately accessing clinical records and as now, EPIC is in place and is an open system which potentially increases that risk. However, EPIC has a stronger and more robust audit ability, and the option to add *'break the glass'* to any record which means it is much easier to identify inappropriate access once it has been reported. I am advised that work is underway to dynamically identify inappropriate access in real time and the Trust is exploring a 'bolt-on' to EPIC which will provide real time flagging of excessive access of a record.

> *Although this is an extreme case there are other examples across the NHS where clinical staff have inappropriately accessed the medical records of their co-workers, neighbours, household members or VIP patients.*
>
> *Whilst education and regular reminders of the expectations and duties is essential, the issues in this case suggests additional safeguards need to be in place to protect employees' and potentially vulnerable patients' medical records from inappropriate access, this should include consideration of software to provide an alert system to highlight potentially untoward variations via real time monitoring to the Senior Information Risk Owner (SIRO). (I understand that this is now under consideration).*

The Trust's response to the NHSE request for an investigation re Dr SK's onboarding.

2.12 The internal investigation which considered the issues regarding onboarding, the actions taken when the matter was first escalated within NDHT in August 2020 and some concerns raised via the helpline was delayed because of the Police investigation.

2.13 Ideally some aspects of that investigation might have been progressed sooner particularly around the onboarding issues.

2.14 I understand that NHSE had not yet shared the learning from the Deanery and the other Trusts which would be useful as part of the wider learning and closure process.

2.15 Although I agree with the core findings of the internal investigation, I cannot reconcile the findings on the notification of the concerns to the Police and compliance with MHPS in 2020 (set out at part 2 – c) with my findings.

2.16 My findings, (paragraph 2.7 above), show that NDHT did not contact the Police when the initial concerns arose, and the actions taken at that time were not fully compliant with the MHPS Policy.

The Trust's response to Court proceedings.

2.17 The decision to arrange a Trust presence at the Court was appropriate and well managed providing real time feedback, a productive link with the Police and was a strong display to the wider stakeholders as to how seriously the Trust viewed this matter.

2.18 I was made aware that some issues about how internal communication had been handled at this time and of particular concerns held by some Governors. However, it seems this relates to a wider communication issue with the Governors which is being considered by the Senior Independent Director (SID).

2.19 My observation on the particular matters on the briefing on Dr SK's case is that when the matter proceeded to Court, it appears to have been well managed and that those who needed to know including the Governors, were appropriately briefed, at the right time consistent with the reporting constraints that been requested by the Court/Police.

2.20 During the course of the review, I was told the arrangements for reporting of serious employment cases involving criminal or high-profile issues to the Board is also under discussion at this time.

2.21 My observation is that increasingly Trusts are ensuring all employment cases involving criminal or high-profile issues or media interest, are reported to the Board replacing the more historic arrangement whereby one employment group i.e. medics, was given greater exposure over other employment groups.

3 Conclusions & Principal Recommendations

Summary Conclusions

3.1 Overall, the response by the Trust to managing the issues relating to Dr SK's case has been well considered and comprehensive and particularly since the receiving the alert from RCHT in April 2021.

3.2 The multidisciplinary approach adopted in 2021 and the decision to work collaboratively with other Trusts and the Police ensured that the Trust complied with its own Policies, statutory responsibilities (notably Duty of Candour), regulatory requirements and that there was timely and proper notification to external bodies.

3.3 Ideally some additional actions could have been taken in 2020 notably to inform the Police, contact the PPA on 28 August 2020 and after receiving additional information on 0 September 2020, to have conducted a second wider check of the named complainant's medical records. However, these actions are unlikely to have prevented or predicted the subsequent course of events.

3.4 It is always very difficult to think the worst of colleagues, and a significant learning which has been observed in high profile NHS cases, is that variations from the norm and disparities in accounts of matters should always prompt curiosity and appropriate investigation before any conclusions are reached.

3.5 Dr SK presented as a convincing and plausible individual and seemingly he was determined and systematic in his efforts to pursue his activities including inappropriately obtaining information from patients and colleagues clinical records.

3.6 Such individuals are not easy to identify, and it is therefore critical that there are sufficient checks and balances within the key areas of risk to provide early warning that something outside normal variation/behaviours is happening and needs to be looked into.

3.7 In this case there are two areas where that approach might have been useful.

3.8 Firstly, improving colleagues' awareness and understanding of indicators of inappropriate behaviours at work and legitimate pathways for such concerns to be appropriately raised.

3.9 Secondly, ensuring that there are sufficient safeguards in place to protect inappropriate access to clinical records by systematically and objectively flagging to the SIRO any activity outside the limits of normal variation.

Principal Recommendations

3.10 Based on the matters considered in this report I would like to offer the following principal recommendations for consideration:

1) Improving and refreshing the awareness of managers who may be involved in MHPS of the advice and support offered by PPA and encouraging them to make early contact.

2) Reminding managers involved in managing employee conduct matters they should arrange for others rather than themselves to provide pastoral support to the employee concerned.

3) Ensuring that there is clear guidance for managers involved in complex employee conduct issues where there is a potential criminal offence that such matters are escalated to the Director of Governance (and executive lead) for advice.

4) Establishing some key principles setting out how the internal communication of significant cases which are likely to attract media coverage will be managed having regard to any reporting restrictions and duty of care to all stakeholders.

5) Reviewing what additional safeguards need to be in place to protect employees' and potentially vulnerable patients' medical records from inappropriate access and consideration of software to provide an alert system to highlight potentially untoward variations via real time monitoring to the SIRO.

Carole Taylor-Brown MSc FCIPD
Independent Reviewer

Completed & Submitted March 2024
Minor Amendments Requested & Applied June 2024

Appendix 1

TERMS OF REFERENCE FOR REVIEW INTO THE MANAGEMENT OF DR SK – NORTH DEVON DISTRICT HOSPITAL

To undertake a review into the Trust's management of Dr SK from identification of allegations through to conviction and sentencing. The review should seek to identify action taken, timeliness and appropriateness of actions and whether the actions were in line with Trust Policy, Regulatory requirements (GMC and CQC) and legislation. The Trust response should include all aspects of the management of the incident including management action, comms and engagement, incident management and duty of candour. In line with the Trust's commitment to a Just and Learning culture – overall the review should seek to identify any opportunity for learning.

1. The Trust's response to concerns raised relating to allegations on Facebook of sexual Assault
2. The Trust's response to the alert from Royal Cornwall Hospital of rape allegations and data breaches
3. The Trust's response to the Police investigation
4. The Trust's response to the request from NHSE to undertake an investigation into the onboarding of Dr SK
5. The Trust's response to court proceedings

Whilst the Trust is keen for the review to look at all five of the areas outlined above, from a risk-based approach the Trust would like a more focused review into the management of the original allegations relating to Facebook, given the rape allegations that shortly followed when Dr SK was working at Royal Cornwall (that he was later charged and sentenced for).

The review should include interviewing key personnel involved in the case, as listed below and also the review, of any emails/reports and correspondence as deemed appropriate.

The list of people identified for interview has been removed for confidentiality and IG compliance.

Acknowledgements

I would like to record my thanks to those who have spoken to me or assisted me in providing documents, which has enabled the timely completion and smooth conduct of matters.

Carole Taylor-Brown MSc FCIPD
Tamarix People Ltd