**CASE OF DR SURESH SRIDHARAN**

**Summary**

Dr Suresh was a 50 year-old senior NHS consultant anaesthetist, of Indian origin, working in Teeside, with an exemplary past work record, who suddenly found himself being the target of sexual allegations by a 15 year-old girl who had undergone dental surgery at a private dental unit located within an NHS Trust. Even though her evidence was later shown to be deeply flawed, and probably related to the side-effects of the anaesthesia, the police and social services treated Dr Suresh as a criminal, and his Trust also suspended him from work. A police referral to the GMC resulted in the GMC sending the consultant an email ordering him to attend a tribunal hearing which could result in him being severely disciplined. A few hours after receiving this email, Dr Suresh took his own life in May 2018. He leaves behind a widow and two teenage sons. An inquest into his death is likely to be held in the next six months.

**Background**

An unsubstantiated sexual allegation was registered as a complaint with the police by a teenage patient under sedation (Midozilam and Fetanyl). The alleged incident was reported to have occurred in the recovery room of a private dental unit within an NHS hospital. This led to series of actions targeted against the consultant anaesthetist, even though there was no clear evidence of him present in the recovery room during the stated period. No formal charges were made against him by the police and flawed evidence that included misidentification was later found to be the basis of the allegation. The consultant was put through stressful interviews with the police, which included the police comparing him to Harold Shipman for denying the allegation during an interview. He was excluded from work by his NHS employer in spite of a longstanding exemplary career as a senior anaesthetic consultant and without the Trust providing/considering any alternative employment options such as continuing to work, but with a chaperone, or working on audit / research projects.

Social services, presumably taking a lead from the police, tormented the family by asking the medical consultant to leave his home, asked their young son to stay away from his father, and taking actions such as informing the son's school and making defamatory remarks about the doctor and his family. At one stage, the police and his NHS employer verbally assured the consultant through a phone call and meeting that there was "no case to answer" and the allegation would not be proceeding any further, but this decision was then reversed.

The consultant’s exclusion from work continued despite the absence of any substantiated evidence of wrongdoing, and every day the doctor was eagerly awaiting a return-to-work date from the Trust. However, a GMC letter asking the doctor to restrict his practice and attend a tribunal hearing came as a complete shock when he was alone at home, and this resulted in his suicide by drowning on May 3, 2018, within a few hours of receipt of the email from the GMC.

**What are the general lessons from this case?**

* The Police
The police in this behaved in almost an identical way to how they behaved in the case of the Carl Beech, the notorious fraudulent individual who caused such terrible distress by telling lies after lies in the form of false sexual allegations about senior, respected individuals in society. There was no consideration by the police of the effects of the medication given to the complainant for anaesthesia, and the fact that such medication is well-established to be associated with sexual hallucinations.
* The police did not cease their investigation once they found that the description of the alleged perpetrator that was given by the patient was in fact quite different to the appearance of the consultant in question.
* The police did not wait till their investigations were completed before making a referral to the GMC.
* The police appeared to fail in their communications with the consultant, at one stage apparently telling him that the case would be closed.
* The police did not seem to have any formal systematic procedures for deciding which case involving a doctor to refer to the GMC.
* The police did not appear to take into account the fact that a large number of police referrals to the GMC turn out to be flawed.
* After Dr Suresh’s death, an internal review carried out into the conduct of the police was not external and independent, and itself was flawed.

There is therefore an urgent need for proper training of police and proper procedures to be put in place to prevent flawed allegations about doctors resulting in referral to the GMC and resulting in harsh actions by other agencies, such as social services.

The GMC
The GMC needs to be more critical in how it deals with referrals from the police. Evidence from the GMC’s own database shows that flawed referrals are most likely to come from the police, yet this does not seem to impact on how the GMC acted in this case, being totally gullible to allegations without seeing if they were based on verifiable evidence and not even waiting for the police investigations to conclude. The GMC seem to have a hypersensitivity to the word ‘sex’, with it seems any sexual allegations automatically leading to a stressful tribunal hearing for a doctor.

In this instance, the GMC sent two simultaneous letters to the consultant, one saying he was being investigated and the other calling him to a hearing. The second letter should have been delayed till the outcome of the first letter was established.

The GMC should never communicate tribunal hearing attendance decisions by email alone. There should always be a phone call, or a video call (or ideally an informal visit by a GMC liaison officer) in advance so that any concerns or anxieties can be dealt with. There should also be a similar oral communication after the written communication is received, as doctors may be such a state of shock after receiving such a communication that they fail to read all of the content of the communication or misread part of it.

Social Services

The behaviour of Social Services in this case was flawed and harsh. They behaved as if the allegations were true, and appeared to have no consideration for the past exemplary history of the doctor and his family, nor any consideration or compassion for the effects of their actions in placing restrictions on Dr Suresh and in contacting the school which his children attended. Their reactions appeared ‘knee-jerk’, with little thought or proper procedure followed. Appropriate training and accountability of social services officers needs to be put in place.

The NHS Trust

When dealing with NHS staff subject to allegations, where possible Trust actions that are entertained should have a choice architecture that works up from those remedies which are effective as safeguards for any concerns / risks (e.g. engagement in non-clinical work such as audit or research or teaching, chaperone when seeing certain patients, etc), but which are focused on the risk and have minimal detriment to the member of staff and his/her family. The impact on the wellbeing of the member of staff and his / her family of any punitive measures should be regularly monitored, on a weekly or more frequent basis.

**Current legal processes**

Two pre-inquest review hearings have been held, and it is anticipated that a full hearing will occur within the next six months. Rule 43 of the Coroners Rules (1984) states that if the Coroner is of the opinion that a death could have been prevented if different action had been taken by concerned organisations, the Coroner can make a recommendation for change. The organisation in receipt of the Coroner’s recommendation (typically in the form of a report) has 56 days by law to respond in writing. The response commonly includes confirmation that a certain practice or protocol has changed following the Coroner’s recommendation.  For example, the NHS Trust or GMC or police or social services may be asked to seriously review one or more of their policies to help prevent similar deaths.

Each of the organisations (police, GMC, social services, NHS Trust and private dental unit) who played major role in the death of Dr Suresh has substantive or unlimited public funding at their disposal to save their own reputation.

**Aim of CrowdJustice appeal**

In order to effectively deal with not one but several legal teams representing organizations who will be trying to defend their actions, the widow of Dr Suresh has to raise funds in a situation where she is now the sole bread-winner for her family and has to support her two teenage children, one of whom has started university. As well as the coroner’s court hearing, there may well be civil hearings in the future which also incur significant costs. We may also need to engage support from professional experts on aspects of the case. After the coroner’s inquest, we may need to bring civil cases against parties shown to be have been guilty.

We are thus aiming to raise £100,000 to meet immediate and likely future costs.

Payment can be made by xxx