COUNCIL FOR HEALTHCARE REGULATORY EXCELLENCE

SECTION 29 CASE MEETING ON 17 JUNE 2005

AT 11 THE STRAND, LONDON WC2

RE: DR BILAL MOHAMED KAZI AND THE DECISION OF THE FITNESS TO PRACTISE PANEL OF THE GENERAL MEDICAL COUNCIL MADE ON 24 MAY 2005

PRESENT: Peter North (Lay Member, in the Chair)
Sally Williams (Lay Member)
Nicholas Wood (Regulatory Member)

IN ATTENDANCE: Briony Mills (Fitness to Practise Officer)
Charles Atkins (Legal Adviser, Bevan Brittan)
Christian Dingwall (Legal Adviser, Bevan Brittan)

The Fitness to Practice Panel's Decision

1. Dr Kazi is a 54 year old registered medical practitioner. He appeared before the Fitness to Practise panel ("the FTP Panel") of the General Medical Council ("GMC") on 23rd and 24th May 2005 in relation to a charge of serious professional misconduct.

2. The FTP panel heard the case in accordance with transitional arrangements under the GMC's Preliminary Proceedings Committee and Professional Conduct Committee (Procedure) Rules 1988 ("the 1988 Rules"). The FTP Panel gave their determination on 24th May 2005.

3. The heads of charge and findings against Dr Kazi were:

Number	Head	Finding
1.	At all material times, you were registered as a medical practitioner in the United Kingdom;	**Admitted and found Proved**
2.	During September 2002 you were employed as a locum registrar in obstetrics at Macclesfield District General Hospital ("the Hospital")	**Admitted and found Proved**
3.	On 26th September 2002;	
	a) at 4.45pm, Ms E was admitted to the hospital in spontaneous labour.	**Admitted and found Proved**
	b) At approximately 11.30pm, Ms E was 9cm dilated with a reactive cardiotocograph. You discussed her progress with the midwife and directed that Ms E be given Syntocinon	**Admitted and found proved**
	c) At approximately 11.45pm, the administration of Syntocinon was commenced at 3ml per hour;	**Admitted and found Proved**
4.	On 27th September 2002;	
	a) At 12.15am, Ms E's contractions were stronger. Syntocinon was increased to 6ml per hour.	**Admitted and found Proved**
	b) At 12.30am,	
	i) Ms E was noted to be fully dilated	**Admitted and found Proved**
	ii) Syntocinon was increased to 12ml per hour	**Admitted and found Proved**
	c) At about 12.40am, Syntocinon was increased to 24ml per hour	**Admitted and found Proved**
	d) At approximately 1am,	
	i) a) Ms E was having hyper frequent uterine contractions, approximately 7 to 8 in 10 minutes	**Admitted and found Proved**
	b) there were obvious signs of fetal distress	**Admitted and found Proved**
	ii) you reviewed Ms E and knowingly allowed the administration of Syntocinon to be continued	**Admitted and found Proved**
	e) You signed the CTG at about 1am	**Admitted and found Proved**

	f) At 1.35am, it was noted that there was slow progress on pushing	**Admitted and found Proved**
	g) At 1.45am, you were in the room and Ms E was being prepared for Ventouse delivery	**Admitted and found Proved**
	h) At 2am, a Kiwi cup was applied	**Admitted and found Proved**
	i) At 2.17am, Ms E's female baby was delivered by the midwife, Susan Davenport,	**Admitted and found Proved**
	j) The baby was not breathing, was given oxygen and was transferred to the Special Care Baby Unit.	**Admitted and found proved**
	k) At approximately 3.05am, the baby started fitting and had renal failure	**Admitted and found Proved**
5.	On 30th September 2002, an MRI scan showed that the baby had multicystic leucoencephalomalacia	**Admitted and found Proved**
6.	At follow-up, the baby was shown to have spastic quadriplegia and severe development delay;	**Admitted and found Proved**
7.	In respect of your aforesaid care of Ms E,	
	a) you did not recognise that there was severe fetal distress when you saw Ms E at around 1am,	**Admitted and found Proved**
	b) you did not recognise that:-	
	i) such distress was caused by uterine hyperactivity	**Admitted and found Proved**
	ii) Such uterine hyperactivitiy was probably induced by excess Syntocinon	**Admitted and found Proved**
	c) you did not ensure that the administration of Syntocinon was stopped.	**Admitted and found Proved**
	d) you did not stay with Ms E for longer than about 12 minutes to observe whether the fetal distress settled down;	**Admitted and found Proved**
8.	You recorded your involvement in Ms E's labour and delivery in a note timed at 12.59am but continuing through until after delivery of the baby,	
	a) you made that note at approximately 7am on 27th September 2002,	**Admitted and found proved**
	b) you did not make any notes relating to your involvement in Ms E's labour and delivery before that note apart from signing the CTG at about 1am and writing up the prescriptions for Syntocinon.	**Admitted and found proved**

9. In respect of your note-keeping,

	Charge	Finding
a)	you failed to keep notes of your care of Ms E that were made either contemporaneously or so soon as reasonably practicable after the events to which they referred,	**Admitted and found proved**
b)	you failed to indicate in the note referred to at Head of Charge 8 above the timing of events referred to in that note,	**Admitted and found proved**
c)	you failed to record why you did not stop the administration of Syntocinon from 12.50am onwards,	**Admitted and found proved**
d)	you failed accurately to record the circumstances of the delivery,	**Admitted and found proved**

10. Your conduct as set out at Heads of Charge 7 and 9 was,

	Charge	Finding
a)	inappropriate,	**Admitted and found proved**
b)	liable to pose a significant danger to the welfare and well-being of Ms E and her baby,	**Admitted and found proved**
c)	likely to bring the medical profession into disrepute,	**Admitted and found proved**
d)	seriously below that to be expected of a Registered Medical Practitioner,	**Admitted and found proved**

And that in relation to the facts alleged you have been guilty of serious professional misconduct.

3. In summary, it was the GMC's case that Dr Kazi failed to notice that there were obvious signs of fetal distress caused by uterine hyperactivity that was probably induced by excess Syntocinon, which Dr Kazi allowed to be continued. In the event the child was subsequently shown to have spastic quadriplegia and severe developmental delay. There was a separate issue in relation to Dr Kazi's notes of the incident which were not written contemporaneously and were not accurate in relation to his involvement or as to timings.

4. On the basis of the facts admitted and found proved, the FTP panel found Dr Kazi not guilty of serious professional misconduct.

Documents

5. The following documents were before the meeting:

(1) Determination of the FTP Panel given on 24th May 2005.

(2) Transcript of Hearing – 23rd and 24th May 2005.

(3) Exhibits before the FTP Panel.

(4) The GMC's Indicative Sanctions Guidance 2004 and 2005.

(5) Report prepared by Bevan Brittan LLP dated 14 June 2005.

(6) Section 29 Process and Guidelines (November 2004).

Conflicts of Interest

6. Mr North declared that he is a lay assessor for the GMC but had no involvement in Dr Kazi's case.

7. The members declared no conflicts and none was apparent.

Jurisdiction

8. The members noted that the purpose of the meeting was to decide whether to exercise its statutory discretion to refer to the High Court under Section 29 of the NHS Reform and Health Care Professions Act 2002 ("the 2002 Act") the FTP Panel's decision in respect of Dr Kazi.

9. It was agreed that the CHRE had the power to refer this case under Section 29(4)(a) of the 2002 Act if they considered that the decision of the FTP Panel was unduly lenient and it was desirable so to refer for the protection of members of the public.

Matters noted by the meeting

10. All the heads of charge were admitted by Dr Kazi and found proved.

11. The FTP Panel had heard no evidence from any witnesses called on behalf of the GMC and only from Dr Bolton on behalf of Dr Kazi; whose evidence did not go to the issue of serious professional misconduct.

12. Dr Kazi had admitted that his conduct in relation to Heads of Charge 7 and 9 was inappropriate, liable to pose a significant danger to the welfare and well-being of Ms E and baby, likely to bring the medical profession into disrepute and seriously below that to be expected of a Registered Medical Practitioner.

13. No criticisms were made by the GMC's expert, Mr Johnson (whose report was not relied upon or disclosed by the GMC) of the decision by Dr Kazi to prescribe Syntocinon in the first instance or of his actions at 01.45.

14. The midwives involved in the care of Ms E do not appear to have followed the hospital's own protocol for the administration of Syntocinon and the GMC's expert was also apparently critical of their care.

15. There was confusion as to the exact dose of Syntocinon that Ms E did receive although Dr Kazi was not part of the confusion.

16. Dr Kazi visited Ms E from approximately 01.00 for 12 minutes. The fetal distress continued after his departure from the delivery suite until his return at 01.45 when he arranged for delivery. Dr Kazi had remained on the labour ward between his first visit at approximately 01.00 and his return at 01.45.

17. After Dr Kazi's review at 01.00 the CTG remained abnormal with further signs of increasing fetal distress, but he was not called back until 01.45.

18. The members noted that although errors were made, they seemed to reflect a failing by the whole team involved in the care of Ms E and took place over a relatively short timescale.

19. The Trust's Perinatal Audit from 20.03.03 advised, inter alia, that CTG training should be mandatory for all midwifery and obstetric staff and that the policy on Syntocinon should be revisited urgently.

20. Dr Kazi had been in the Special Care Baby Unit for approximately 3 – 4 hours between the delivery at 02.17 hours and approximately 07.00 when he came to write up his notes.

21. It was noted by the meeting that the notes made by Dr Kazi were not contemporaneous; that they did not accurately record the timing of his involvement; that they did not explain why he did not stop the administration of Syntocinon from 00.50 onwards and that they failed accurately to record the circumstances of the delivery.

22. That Dr Kazi had no serious errors of clinical judgment that had been the subject of an investigation previously before the GMC.

23. Dr Kazi has attended and completed a number of courses since the incident in September 2002 including the K2 Foetal Monitoring, teaching and simulation model in October 2002 and May 2003, although the members noted that there was no evidence heard or produced, making it difficulty to know whether any other steps were required.

24. That Dr Kazi had the support and confidence of Dr Bolton, his consultant at the hospital where he now works, who assessed his abilities at the level she would expect from someone with Dr Kazi's training.

25. The members noted an isolated incident of clinical negligence could amount to serious professional misconduct and that it was for the FTP Panel to ascertain whether the admitted conduct was sufficiently serious to amount to serious professional misconduct. The members also noted that appropriate legal guidance was given in light of *Preiss v GDC* and *R (on the application of Jennifer Campbell) v The GMC* [2005]. EWCA Civ 250 [2001] 1 WLR 1926].

26. The members considered that the error by Dr Kazi, although serious, was not wilful or reckless.

27. The members noted that no expert evidence was before the FTP Panel and that this would have made it harder for them to reach a view on whether the conduct admitted and proved amounted to serious professional misconduct.

28. The members also noted the sentiments of Dame Janet Smith in the Fifth Report of the Shipman Inquiry who noted (at page 953 vol 3) that although the GMC can and do consider cases of negligence which are sufficiently serious, such cases do not fit easily within the range of "deficient professional performance" or "misconduct". She recommended that there should be a new category of "deficient clinical practice" to

cover isolated or nearly isolated serious error, committed not deliberately or recklessly, but negligently.

29. It would not have been appropriate to consider this case under the “deficient professional performance” procedures of the GMC as there was no “pattern of serious failures”.

Members Consideration

30. The members considered the issue of public protection both in terms of the extent to which Dr Kazi and his actions represented a danger to patients and in terms of maintaining the reputation of the profession and public confidence in regulation.

31. The members considered that in light of the confidence expressed in Dr Kazi by his Consultant Dr Bolton, the re-training that he had undertaken, the expressions of regret and insight that he had shown, together with the time that has elapsed since this incident took place, that he did not represent a danger to patients.

32. On the basis of the findings of the FTP Panel and evidence put before it, the members accepted that Dr Kazi’s admitted failings were an isolated occurrence. His case did not raise issues of general competence or performance as a doctor.

33. The members considered that the absence of a finding of serious professional misconduct was reasonable in the circumstances of the case.

34. The members believed that Dr Kazi was fully cognisant of the gravity of his conduct.

35. But the members considered that the issue of public protection was limited such that the case should not be referred to the High Court.

36. In view of their conclusion about public protection, the members did not go on to determine whether or not the decision was unduly lenient.

Conclusions

37. The members concluded that the case did not raise an issue of public protection such that the case should be referred to the High Court.

38. In light of the absence of public protection issues, it was not necessary to determine whether the decision was unduly lenient.

39. The meeting therefore decided not to refer the case to the High Court.

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(Chair) **Dated**

Time of commencement of meeting: 13.35

Time of conclusion of meeting: 14.50