COUNCIL FOR HEALTHCARE REGULATORY EXCELLENCE
NOTE OF SECTION 29 CASE MEETING ON 22 NOVEMBER 2005

AT 11 STRAND, LONDON, WC2
Re: Dr Murtaza Husain Husaini

PRESENT: Jane Wesson (Chair)
Jonathan Asbridge (Regulatory member)
David Smith (Lay member)

IN ATTENDANCE: Professor Julie Stone (Deputy Director, CHRE)
Mike Andrews (Fitness to Practice Manager, CHRE)
Briony Mills (Fitness to Practice Officer, CHRE)
Ruth Tomlinson (Section 29 Legal Secondee, CHRE)
Len Murray (Associate, Baker & McKenzie, Legal Advisor)
Andrew Hill (Associate, Baker & McKenzie)
Zoe Wittington (Observer)

1. DEFINITIONS

In this note, the following abbreviations will apply:

"CHRE"	Council for Healthcare Regulatory Excellence
"Dr Husaini"	Dr Murtaza Husain Husaini
"Dr Shipman"	Dr Harold Shipman
"SPM"	Serious Professional Misconduct
"The 2002 Act"	NHS Reform and Healthcare Professions Act 2002
"The Council"	CHRE as constituted for this Section 29 Case Meeting
"The FPP"	Fitness to Practice Panel of the GMC (sitting as the Professional Conduct Committee under the GMC's previous Rules).
"The GMC"	General Medical Council

2. THE FPP'S DECISION

The Council considered whether the decision of the FPP on 27 October 2005 to find Dr Husaini guilty of SPM and to issue him with a reprimand should be referred to the High Court under section 29 of the 2002 Act.

The charges which Dr Husaini faced before the FPP concerned:

- his actions and omissions during 1994 and 1995 when, as Joint Director of the Intensive Care Unit at Tameside District General Hospital, he was responsible for the care of a certain Mrs A, who had been admitted to Tameside as a result of treatment by her GP, Dr Shipman, for an asthma attack; and

- the evidence which he gave in 2002 concerning those actions and/or omissions to the Shipman Inquiry chaired by Dame Janet Smith.

After treating Mrs A's asthma attack with a nebuliser, Dr Shipman had administered a 20mg dose of morphine to Mrs A all at once, rather than titrated against her response. She had then suffered a respiratory arrest. Dr Husaini admitted to the FPP that he knew, or ought reasonably to have known that the recorded dose of morphine was grossly excessive; that,

in whatever dosage it was given, morphine should always be titrated against a patient's response; and that Mrs A's respiratory arrest was due to the administration of morphine by Dr Shipman. Mrs A remained in a comatose state in the ICU for approximately 14 months before she died in April 1995.

3. DOCUMENTS

The following documents were available to the Council:

- The transcript of the hearing before the FPP (dated 3 - 27 October 2005);
- The exhibits tendered to the FPP on behalf of the GMC and Dr Husaini;
- The Determination of the FPP dated 27 October 2005;
- A Report prepared by Baker & McKenzie LLP dated 17 November 2005;
- The GMC's Indicative Sanctions Guidance (May 2004 and April 2005);
- CHRE's Section 29 Case Meeting Manual; and
- CHRE's Section 29 Process and Guidelines (November 2005).

4. CONFLICTS OF INTEREST

The Chair informed the Council that the members convened had no apparent conflicts of interest. No conflicts of interest were then registered.

5. MATTERS NOTED BY THE COUNCIL

The Council noted the matters set out below:

5.1 The FPP's findings of fact.

The FPP found that Dr Husaini had not made misleading statements to the Shipman Inquiry regarding reporting his concerns to certain individuals (Mr Butterworth, Chief Executive Designate of Tameside, Mrs Nuttall, Business Manager of Tameside and Mr Revington, the Coroner), but found that Dr Husaini had made a misleading statement to the Shipman Inquiry regarding reporting his concerns to Mr Howorth (the Legal Advisor to the then North West Regional Health Authority).

Dr Husaini had relied before the Inquiry on the letter which he had sent to Mr Howorth on 24 March 1994 (the "Letter"). The FPP found Dr Husaini had misled the Inquiry in stating that the Letter voiced his concerns as to the administration of morphine as well as seeking advice from Mr Howorth about the future treatment of Mrs A, but the FPP did not find that he had been dishonest in making this statement to the Inquiry. The FPP also found that Dr Husaini represented in the Letter that the morphine had been given to Mrs A because she had become "very restless", when there was no record that that was the reason why the morphine was given; it would have been wrong to give morphine for restlessness; and Dr Husaini did not explain that it was wrong or inappropriate to give morphine for restlessness.

In addition to Dr Husaini’s misleading statements to the Shipman Inquiry, the FPP found that at the time Mrs A was in his care, Dr Husaini did not in fact make adequate inquiries to discover why the morphine had been administered and did not report any concerns about the administration of the morphine to either Mr Howorth or the Medical Director Designate of Tameside. The FPP considered that, as Consultant in charge of Mrs A, Dr Husaini had been the most appropriate person to take action.

5.2 The FPP's finding of SPM

The basis for the FPP's finding of SPM was as follows:

> *"You represented that, when you wrote to Mr Howorth on 24 March 1994, you were expressing concern about the administration of morphine to Mrs A by Dr Shipman, that it was wrong and you expected that it would be investigated.*
>
> *The Panel has found that your evidence to the Shipman Inquiry was untrue or misleading in that you did not express concern in your letter of 24 March 1994 about the administration of morphine to Mrs A by Dr Shipman and that it was wrong.*
>
> *The Panel has found that your actions as just described were inappropriate, irresponsible, unjustifiable and likely to bring the medical profession into disrepute.*
>
> *…*
>
> *You made many admissions neutrally, however the substance of the heads of charge found proved lies in the fact that you did nothing effective to bring your concerns to the proper authorities. As Consultant in charge of Mrs A, you were the most appropriate person to take action in this case, particularly when, as indicated to the Panel in evidence, you were at pains to point out how strongly you felt about the treatment which Mrs A had received from her GP, Dr Shipman."*

5.3 The FPP's sanction - reprimand

Having made the findings above and having considered the GMC's Indicative Sanctions Guidance, the FPP issued Dr Husaini with a reprimand. In so doing, it made the following comments:

> *"It is significant that the Panel has not made a finding of dishonesty in this case. Although you did mislead the Inquiry, you also misled yourself into believing, as you have said, that your letter adequately expressed your concerns.*
>
> *…*
>
> *In hindsight, you now accept that you should have taken matters further than you did in writing the letter to Mr Howorth, which may have avoided significant risk of indirect harm to other patients…[But] you could not have been aware of Dr Shipman's murderous predisposition.*
>
> *…*
>
> *The only culpable finding that the Panel made against you was in relation to your failure to convey your concerns regarding Mrs A in the letter which you sent to Mr Howorth. ….This was a single, isolated incident from which you have learned a salutary lesson. …The GMC's Indicative Sanctions Guidance published in May 2004 states that "A reprimand, therefore, may be appropriate where the offence is at the lower end of the spectrum of serious misconduct in order to mark the fact that the behaviour was unacceptable and must not happen again." The Panel has therefore determined to conclude this case with a reprimand."*

6. APPLYING SECTION 29 OF THE 2002 ACT

6.1 Public protection

The Council did not consider that the circumstances of the case and the FPP's decision gave rise to sufficient concerns for public protection to satisfy the criteria in section 29 of the 2002 Act.

In arriving at this conclusion, the Council considered the following matters:

(a) As noted above, the FPP had made findings that Dr Husaini failed to report his concerns at the time to Mr Howorth and to the Medical Director Designate at Tameside. However, Dr Husaini is now approximately 71 years of age and is only practising to a very limited extent, having retired from Tameside in May 1999. The Council considered that Dr Husaini did not represent a direct danger to patients. A period of 11 years had also passed since the initial events in question.

(b) The FPP had heard Dr Husaini and concluded that he had not been dishonest in giving evidence to the Shipman Inquiry. The Council was mindful of giving weight to the views of panels who have had the benefit of hearing the evidence of witnesses before them, but acknowledged that the Council is still entitled to assess whether it considered a panel's finding to be wrong.

(c) The Council sought clarification as to the legal meaning of "dishonesty". The Council was directed to the test set out by Lord Lane for fitness to practice panels in the case of *Ghosh* [1982] Q.C. 1053., specifically that the test contains two parts: a subjective element and an objective element.

(d) The Council considered the following extracts from the Determination:

"The question of dishonesty involves an intention to mislead. The FPP did not find [Dr Husaini's] evidence to the Inquiry about the letter to Mr Howorth to be dishonest."
…
"It is significant that the Panel has not made a finding of dishonesty in this case. Although you did mislead the Inquiry, you also misled yourself…"

(e) The Council considered that the FPP's reasons for its finding on dishonesty were not clearly expressed. The Council was referred to the case of *CRHP v GMC & Basiouny* [2005] EWHC 68 (31 January 2005 per Richards J): first, as an example of a case in which an FPP appeared to have made a finding, but did not provide an explanation of the finding; and secondly, to advise the Council that CHRE can only refer a case in relation to findings of fact in exceptional circumstances, where the finding is "manifestly wrong". The Council did not consider that the FPP's finding was manifestly wrong.

(f) The Council considered the terms of the Letter and the evidence about it that Dr Husaini had given to the Shipman Inquiry and to the FPP.

(g) The FPP, in its Determination, had put the culture which the FPP recognised existed in 1994 and 1995 (which was that doctors did not report other doctors' clinical malpractice to the proper authorities or at all) out of their minds and looked instead at Dr Husaini's individual duty. The Council considered the FPP was entitled to take this approach but noted that Dr Husaini's evidence to the Shipman Inquiry was given in 2002 when the culture had started to change.

(h) In terms of context, the Council noted that it was aware of other developments within the medical profession to address the need for cultural change, such as the recommendations of the Shipman Reports, the report of Professor Sir Ian Kennedy and key statements on policy issued by the Department of Health and the GMC.

6.2 Undue lenience

Having concluded that the circumstances of the case and the FPP's decision did not give rise to sufficient concerns for public protection to satisfy the criteria in section 29 of the 2002 Act, the Council was not required to consider whether the sanction imposed by the FPP was unduly lenient.

The Council considered it appropriate in the circumstances of this case, however, to express a view. Given the matters noted above, the Council did not consider in all the circumstances that the imposition of a reprimand was manifestly inappropriate.

6.3 Discretion

As the criteria in section 29 of the 2002 Act were not fulfilled, CHRE's discretion to refer the case to the High Court did not arise.

6.4 The Shipman Reports

The Third and Fifth Reports of the Shipman Inquiry were available to the Council as background. Having concluded that the circumstances of the case and the FPP's decision did not give rise to sufficient concerns for public protection to satisfy the criteria in section 29 of the 2002 Act, the Council decided it was not necessary to consider them.

7. CONCLUSION

The Council concluded that:

1. It had jurisdiction under section 29 of the 2002 Act to consider whether or not to refer the case to the High Court.

2. Based on the matters noted by the Council in sections 5 and 6 above, it was not desirable for the protection of members of the public for CHRE to exercise its jurisdiction to refer this case to the High Court and, although it was not required to consider it, the sanction imposed by the FPP was not unduly lenient.

3. As such, the criteria in section 29 of the 2002 Act were not fulfilled. Accordingly, there was no basis on which to exercise CHRE's discretion to refer the matter to the High Court.

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JANE WESSON (Chair) DATE