PUBLIC RECORD

Dates: 23/05/2024

Medical Practitioner's name:	Dr Daniel HAIGH
GMC reference number:	6158682
Primary medical qualification:	MB ChB 2007 University of Leeds

Type of case	**Outcome on impairment**
Review - Misconduct	Not Impaired

Summary of outcome

Conditions Revoked

Tribunal:

Legally Qualified Chair	Miss Megan Larrinaga
Lay Tribunal Member:	Mrs Hannah De Merode
Medical Tribunal Member:	Dr Paul Mitchell

Tribunal Clerk:	Ms Fiona Johnston

Attendance and Representation:

Medical Practitioner:	Present, not represented
GMC Representative:	Mr Dale Hughes, 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 Impairment - 23/05/2024

1. At this review hearing the Tribunal has to decide in accordance with Rule 22(1)(f) of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended ('the Rules') whether Dr Haigh's fitness to practise is impaired by reason of misconduct.

The Outcome of Applications Made during the Facts Stage

2. At the hearing Dr Haigh indicated that he wished to admit into evidence his written reflections. Mr Hughes, Counsel, on behalf of the GMC did not oppose the application.

3. The Tribunal took account of Rule 34(1) of the General Medical Council the Rules which provides that "… *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."*

4. The Tribunal granted the application as it considered that the written reflections would assist the Tribunal in determining the level of Dr Haigh's insight. It further considered that the prejudice to Dr Haigh in not admitting his written reflections would far outweigh any prejudice in admitting the document.

5. Accordingly, the Tribunal granted Dr Haigh's application.

Background

6. Dr Haigh qualified with an MB ChB in 2007 from the University of Leeds. At the time of the events, Dr Haigh was employed as a Non-Consultant Career Grade Speciality Doctor in Anaesthesia by the Calderdale and Huddersfield NHS Foundation Trust ('the Trust'). He had held this position since August 2012. Dr Haigh had also volunteered as a doctor for St John's Ambulance Services ('St John's') since 2001.

7. The background to the matters are that on four separate occasions between 19 May 2017 and 21 January 2018, Dr Haigh while acting as a St John's medical escort, administered quantities of controlled drugs including ketamine, diazepam and diamorphine, to Patient A to assist with pain management. The controlled drugs administered by Dr Haigh were not clinically indicated and the doses exceeded the maximum recommended dosage. At the time of administering the controlled drugs Dr Haigh was not anaesthetic specialist, there was no resuscitation equipment available and Dr Haigh, on more than one occasion failed to transfer Patient A to a hospital.

The 2021 Tribunal

8. A Medical Practitioners Tribunal ('MPT') hearing took place between 14 and 21 January 2021 ('the 2021 Tribunal'), Dr Haigh admitted, and the 2021 Tribunal found proved, the entirety of the Allegation.

9. The 2021 Tribunal went on to consider the matter of impairment in relation to Dr Haigh's misconduct. It noted that Dr Haigh's actions were not an isolated event and that he had administered an excessive dose of medication on at least four different occasions, over a period of time, which could have resulted in serious harm towards Patient A. It considered that the combination of drugs administered over a relatively short period on each occasion demonstrated an inexperienced doctor struggling to find a way to manage Patient A's pain, but without sufficient regard to the potential cumulative effect of the medication and to their safety. The 2021 Tribunal was of the view that it should have been readily apparent to Dr Haigh on each occasion that the escalating events took the treatment of Patient A beyond his area of competence, and that it was inappropriate for him to continue to treat Patient A.

10. The 2021 Tribunal took into account Dr Haigh's evidence and particularly his recognition that his actions were inappropriate and beyond the limit of his competence at the time of the events. It considered that Dr Haigh's conduct fell seriously short of the standards expected of doctors so as to clearly amount to misconduct, which was serious. The 2021 Tribunal concluded that Dr Haigh's conduct had put Patient A at unwarranted risk of harm, brought the medical profession into disrepute and breached a fundamental tenet of the profession.

11. The 2021 Tribunal accepted that Dr Haigh had developed some insight into his failings. He appeared to realise that he had treated Patient A in a situation beyond his competence on each occasion. Dr Haigh had taken steps to remediate, namely that he had undertaken a new role with the Mid-Yorkshire Trust where, working under close supervision, he was seeking to develop his skills. However, the 2021 noted that Dr Haigh's learning was primarily based on clinical topics rather than targeted to his specific failings.

12. Dr Haigh had apologised for his treatment of Patient A during his evidence and the 2021 Tribunal was of the view that he had expressed genuine remorse and regret. However, the 2021 Tribunal was of the view that Dr Haigh's demonstration of reflection and remediation, provided in his oral evidence and witness statement, primarily revolved around himself, his career and his inability to practice medicine, rather than the risk to the life of Patient A as a result of his actions. Furthermore, Dr Haigh did not demonstrate to the 2021 Tribunal how he would act differently in the future, if faced with a similar situation. The 2021 Tribunal took into account the supportive environment of peers Dr Haigh had in his new role, and that he had begun to use the opportunities for learning that his new employer offered. The 2021 Tribunal concluded that, in the circumstances, Dr Haigh's insight and process of remediation remained incomplete.

13. The 2021 Tribunal considered that Dr Haigh's conduct was a serious breach of the standards expected of a doctor and inevitably brought the medical profession into disrepute, had the potential to endanger patients and undermined public trust in the profession. Therefore, it considered that a finding of impairment was necessary to protect and promote the health, safety and well-being of the public, to maintain public confidence in the medical profession and to uphold proper professional standards and conduct for members of the medical profession. Further, the 2021 Tribunal noted that Dr Haigh had accepted that he was impaired at that time and that he still had work to do.

14. The 2021 Tribunal determined that the proportionate sanction was conditional registration for a period of 24 months. It considered that this was the minimum period necessary to allow Dr Haigh to continue addressing his insight within a supportive NHS clinical environment, whilst giving him the time to demonstrate that he can return to work at the level expected of a medical practitioner at his stage of training.

The February 2023 Tribunal

15. Dr Haigh's case was reviewed by an MPT on 3 February 2023 ('the February 2023 Tribunal'). Dr Haigh gave oral evidence at that hearing. He stated that he felt ready to work independently but accepted that he may not have submitted the necessary evidence to prove that. Dr Haigh accepted that he had overlooked the recommendation of the 2021 Tribunal that he provide written evidence of further reflection for the review hearing and acknowledged that his organisational skills were '*terrible*.'

16. The February 2023 Tribunal was satisfied that Dr Haigh had complied with his conditions for the previous two years and worked hard to improve his clinical skills. Dr Haigh's supervisors were satisfied that he could undertake an anaesthetic list without

supervision. However, there were ongoing concerns in relation to his organisation skills. The February 2023 Tribunal considered that improving these skills would be of great benefit to Dr Haigh as it would help him both personally but also in his career.

17. The February 2023 Tribunal noted that, although Dr Haigh had provided some written reflections, they had primarily focussed upon his learnings from CPD with some assessments of dealing with particularly challenging incidents or patients. It noted that there was only one document which reflected specifically upon his treatment of Patient A and his actions that led to the findings of misconduct, and that document was not particularly detailed. The February 2023 Tribunal was not satisfied that there was evidence before it that Dr Haigh had reflected sufficiently upon his past actions, the impact his actions may have had on Patient A, the impact on public confidence in the profession and how he would deal differently with a similar situation in the future.

18. The February 2023 Tribunal also noted that the 2021 Tribunal had recommended that it may assist if Dr Haigh provided evidence of career development. It noted that he had provided a detailed PDP showing his clinical progress since 2021 but had not included any personal development actions with that PDP, which the Tribunal would have expected to see.

19. The February 2023 Tribunal was of the view that there remained a persistent concern that Dr Haigh had not appreciated the findings made against him from the patient's perspective and that he had not expressed this in a clear, cogent manner. The February 2023 Tribunal concluded that, whilst there had been some insight and remediation, it was not yet complete. The February 2023 Tribunal could not be satisfied that Dr Haigh had developed sufficient insight into his actions and the reasons behind them that would sufficiently mitigate the risk of repetition.

20. The February 2023 Tribunal considered that Dr Haigh had not demonstrated that he had sufficiently addressed the concerns in the case and therefore determined that his fitness to practise remained impaired by reason of misconduct.

21. When considering sanction, the February 2023 Tribunal was of the view that Dr Haigh required a supportive environment to enable him to continue to progress towards achieving full insight. It noted that Dr Haigh's colleagues had been helping him to learn from his past misconduct and take steps to improve his practice, which conditions would allow him to continue. The February 2023 Tribunal was satisfied that it was able to formulate conditions which would allow Dr Haigh to continue to practise and gain the knowledge and experience he needs, whilst also developing his insight.

22. The February 2023 Tribunal was of the view that Dr Haigh needed to add more personal developments to his PDP, such as how he might develop his judgement and resilience in difficult clinical situations. The February 2023 Tribunal was also of the view that he needed to reflect further to develop his insight on the impact on Patient A and public confidence and present it in a focussed written piece.

23. In all the circumstances, the February 2023 Tribunal considered that imposing conditions on Dr Haigh's registration was the appropriate sanction required to protect 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 the profession. The February 2023 Tribunal determined to impose conditions for a period of nine months to allow Dr Haigh sufficient time to reflect, develop and document his insight, particularly into the impact of his actions on Patient A, the public interest and patient safety.

24. The February 2023 Tribunal directed a review of Dr Haigh's case. It noted that the onus was on Dr Haigh to demonstrate how he had reflected on his actions, developed insight and taken steps to remediate. It noted that it may assist the reviewing Tribunal if Dr Haigh provided:

- A documented personal reflection on his past actions (including the impact on Patient A), the journey since and the impact of his actions on public confidence and patient safety;
- Written reflections on his learning in respect of his PDP, with particular focus on the two areas the Tribunal has identified in condition 5 (Clinical judgement and decision making with particular reference to risk management and Developing judgement and resilience in difficult clinical situations);
- Up to date written reports from his responsible officer, educational supervisor, and his clinical supervisor; and
- Evidence of ongoing appropriate CPD.

<u>The December 2023 Tribunal</u>

25. Dr Haigh's case was reviewed again by an MPT on 10 November 2023 but concluded on the 1 December 2023 ('the December 2023 Tribunal'). The December 2023 Tribunal noted that the February 2023 Tribunal had made it clear that at the review hearing the onus would be on Dr Haigh to demonstrate how he has reflected on his actions, developed insight and taken steps to remediate. It suggested that he provide a number of documents which may assist this reviewing Tribunal.

26. The December 2023 Tribunal had regard to Dr Haigh's PDP but noted that Dr Haigh had not provided any written reflections on his learning, as suggested by the February 2023 Tribunal.

27. The December 2023 Tribunal had regard to the reports from Dr Haigh's supervisors. The Tribunal noted that, they were some comments about his poor organisational skills in those reports, however they were no issues with Dr Haigh's clinical knowledge and skills required to undertake his role.

28. The December 2023 Tribunal was encouraged by the positive recent reports by his supervisors, but it was not satisfied that Dr Haigh had developed sufficient insight into his actions and the reasons behind them that would sufficiently mitigate the risk of repetition.

29. The December 2023 Tribunal therefore determined that Dr Haigh's fitness to practise was impaired by reason of his misconduct.

30. The December 2023 Tribunal considered that the current conditions in place on Dr Haigh's registration continued to be appropriate. The December 2023 Tribunal considered six months was sufficient for Dr Haigh to update his PDP, provide written reflections and undertake CPD.

31. The Tribunal determined to direct a review of Dr Haigh's case. It noted that it may assist the reviewing Tribunal if Dr Haigh provided:

- Completed written personal reflection on the impact of his actions on Patient A and on public confidence in the profession and patient safety.
- Written reflections on his learning in respect of his updated PDP, with particular focus on the two areas the Tribunal has identified in condition 5;
- Up to date written reports from his responsible officer, educational supervisor, and his clinical supervisor; and
- Evidence of ongoing appropriate CPD.

Today's Review Hearing

The Evidence

32. The Tribunal has taken into account all the evidence received, both oral and documentary.

33. The Tribunal received documentary evidence which included, but was not limited to: previous Determinations of the MPT hearings dated 14-21 January 2021; 3 February 2023 and 10 November 2023 - 1 December 2023; Email exchanges, workplace report dated 6 March 2024, his approved PDP, a clinical and educational report dated 14 March 2024 and Dr Haigh's written reflections.

Submissions

34. On behalf of the GMC, Mr Hughes reminded the Tribunal of the evidence the December 2023 Tribunal had indicated would be helpful to have before it in determining whether Dr Haigh's fitness to practise remained impaired. He submitted that while there was evidence from Dr Haigh's educational and workplace supervisors there were no written reflections from Dr Haigh in advance of the hearing. Mr Hughes submitted that in the absence of written reflections, Dr Haigh's fitness to practise remained impaired by reason of misconduct.

35. Having had sight of Dr Haigh's written reflections, Mr Hughes, submitted that the GMC were neutral on the issue of impairment and that it would be a matter for the Tribunal to determine.

36. Dr Haigh submitted that the main events happened a number of years ago and at the time he made admissions to all the allegations against him. He submitted that it was his hope that the admissions would help him improve, remediate his misconduct and develop in the future. He accepted that his remediation would be an ongoing process.

37. He submitted that he has significantly changed his clinical practice and no longer works outside of the hospital environment and had been working with his Responsible Officer to be revalidated despite the challenges including not working for a period of time. He further submitted that he had been working with his supervisors to ensure he is providing safe and effective care to his patients. He further stated that he is taking part in clinical governance meetings and working with all the frameworks within the department.

38. On questioning by the Tribunal as to his reflective statement and why it was produced so late he stated that he found the process very difficult but he had worked with his mentor and other colleagues to obtain feedback and support in completing the written reflection. He again submitted that he would always have to work on his reflections.

The Relevant Legal Principles

39. The Tribunal reminded itself that the decision of impairment is a matter for the Tribunal's judgement alone. As noted above, the previous Tribunal set out the matters that a future Tribunal may be assisted by. This Tribunal is aware that it is for the doctor to satisfy it that he would be safe to return to unrestricted practise.

40. This Tribunal must determine whether Dr Haigh's fitness to practise is impaired today, taking into account his conduct 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.

The Tribunal's Determination on Impairment

41. The Tribunal had regard to the findings of the 2021 and 2023 Tribunals, including their findings of Dr Haigh's insight and reflections and the further evidence that it thought might be of assistance in determining whether D Haigh's fitness to practise remained impaired.

42. The Tribunal noted Dr Haigh has worked with conditions imposed on his registration for a period of three years and that no further concerns had been raised. It noted the evidence from his Workplace Reporter and Educational Supervisor that Dr Haigh was a valued member of the team and he worked well within the department. The Tribunal noted the evidence given by Dr Haigh in previous Tribunals that he no longer worked at events and coupled this with his evidence at this hearing that he had changed his clinical practice and only practised in hospital settings.

43. In considering Dr Haigh's written reflections the Tribunal noted that he considered the circumstances which had led to the 2021 Tribunal and how he could avoid such a situation recurring. The Tribunal further noted that Dr Haigh had now reflected on the impact of his actions on Patient A and public confidence in the profession.

44. The Tribunal also noted that the reflective piece included evidence as to the work he had done and continues to do in developing and continuing to improve his clinical skills and had been involved in helping junior colleagues develop their own skills.

45. The Tribunal was satisfied that Dr Haigh had taken sufficient time to develop his reflections since the December 2023 Tribunal and accepted his evidence that he had sought the support of colleagues and his mentor in producing his reflections. The Tribunal noted with encouragement Dr Haigh's evidence that he would continue his reflections in the future.

46. In light of the evidence before it, the Tribunal was satisfied that Dr Haigh had sufficiently reflected on his conduct which led to the 2021 Tribunal. The Tribunal was also satisfied that Dr Haigh had fully reflected on the impact of his actions on Patient A and the public and that he now had full insight into his conduct. The Tribunal also had regard to the fact that there were no current clinical concerns in respect of Dr Haigh, his updated personal development plan, his remediation and full insight into his conduct, and was satisfied that the risk of repetition was very low.

47. The Tribunal has therefore determined that Dr Haigh's fitness to practise is not impaired by reason of misconduct.

48. The Tribunal noted that the conditions on Dr Haigh's registration is due to expire on 6 June 2024. In the light of its findings on impairment, the Tribunal therefore determined to revoke the conditions with immediate effect. It was of the view that this was both appropriate and proportionate in the circumstances of this case.

49. That concludes this case.