PUBLIC RECORD

**Date**: 10/11/2023 and 1/12/2023

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| **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** |
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| Review - Misconduct | Impaired |

**Summary of outcome**

**Conditions, 6 months**
**Review hearing directed**

**Tribunal:**

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| Legally Qualified Chair: | Ms Sirah Abraham |
| Lay Tribunal Member: | Mrs Ann Bishop |
| Medical Tribunal Member: | Dr Carl Egdell |

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| Tribunal Clerk: | Mrs Jennifer Coakley – 10/11/2023<br>Ms Racheal Gill – 1/12/2023 |

**Attendance and Representation:**

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| Medical Practitioner: | Present, not represented |
| Medical Practitioner's Representative: | N/A |
| GMC Representative: | Ms Laura Kaye, Counsel - 10/11/2023<br>Mr Neil Shand, Counsel - 1/12/2023 |

## 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 - 10/11/2023

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 Impairment Stage

2. The Tribunal granted the GMC's application, made pursuant to Rule 34(1) of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'), to admit two further documents as evidence: reports from Dr F, Clinical & Educational supervisor and Dr G, Workplace reporter, both dated 8 November 2023. The Tribunal agreed that the reports were relevant to the case and that it would be fair to admit them as they are very recent and demonstrate the current position. It noted that Dr Haigh did not oppose the application.

## Background

3. 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.

4. The background to the matters are as follows: On 19 May 2017, while acting as a St John's medical escort, Dr Haigh accompanied Patient A, who had recently undergone back surgery, on a trip from Scunthorpe to Maidenhead to assist with pain management. During the journey, Dr Haigh administered a quantity of controlled drugs, including ketamine, to Patient A. The controlled drugs administered by Dr Haigh were not clinically indicated and the doses exceeded the maximum recommended dosage. In respect of the ketamine, this was given despite the fact that Dr Haigh was not an anaesthetic specialist, and when there was no resuscitation equipment available. Dr Haigh also failed to transfer Patient A to a hospital.

5. Dr Haigh later accompanied Patient A on the return journey, on 21 May 2017. He again administered a quantity of controlled drugs including ketamine, which exceeded the maximum recommended dose and was given despite Dr Haigh not being an anaesthetic specialist or having access to resuscitation equipment. He again failed to transfer Patient A to a hospital.

6. On 21 January 2018, Dr Haigh attended a training weekend, at which Patient A was also present. During the course of the weekend, Patient A suffered severe pain, and Dr Haigh again administered a quantity of controlled drugs including ketamine. Those administrations exceeded the recommended maximum dosage and were not clinically indicated. The ketamine was administered despite the fact that Dr Haigh was not an anaesthetic specialist, and where there was no resuscitation equipment available. Dr Haigh was also criticised for not transferring Patient A to hospital in a paramedic crewed ambulance (although she was subsequently taken to hospital).

7. On 4 August 2018, Dr Haigh was on volunteer duty for St John's with Patient A at a public event. During the event, Patient A again suffered severe pain and was treated by Dr Haigh. As before, Dr Haigh administered a combination of controlled drugs including ketamine. The use of the drugs was not clinically indicated, and the dose of diamorphine provided exceeded the recommended maximum dose. Dr Haigh was again criticised for administering ketamine, and for not arranging for Patient A to be taken to hospital in a paramedic crewed ambulance.

The 2021 Tribunal

8. At a Medical Practitioners Tribunal ('MPT') hearing which 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. Dr Haigh admitted that he was not an anaesthetic specialist on the basis that whilst he was trained in anaesthetics, he was not on the specialist register.

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 there seemed to be aspects of Dr Haigh's experience that he could have drawn upon to answer questions put to him by that Tribunal, but he needs to reflect further to develop this and present it in a focussed written piece that clearly demonstrates his insight.

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.

## The Evidence

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

26. Dr Haigh gave oral evidence at the hearing. He confirmed that his fixed-term contract with Mid Yorkshire Hospitals NHS Trust ended in August 2023 and he commenced in a new post at Airedale NHS Foundation Trust on 13 September 2023 as a Trust Registrar in anaesthetics. Dr Haigh stated that he has been struggling with various pressures and feels that he has got into a cycle where he does not believe in himself. He stated that, as a result of this, he has struggled to put pen to paper and provide the relevant written evidence as suggested by the February 2023 Tribunal. Instead, he outlined verbally how he has reflected upon his misconduct and developed his insight. Dr Haigh confirmed that he had not recently met with his previous mentor, Dr D, but that a new mentor has been identified at his current workplace. Dr Haigh stated that he has not as yet arranged to meet with them but has been receiving support on a regular basis from clinical and educational supervisors and workplace reporters.

27. The Tribunal received documentary evidence which included, but was not limited to:

- Record of Determination of the 2021 MPT hearing;
- Record of Determination of the February 2023 MPT hearing;
- Report from Dr B, Workplace reporter and Clinical supervisor, dated 24 May 2023;
- Report from Dr C, Educational supervisor, dated 6 June 2023;
- Email from Dr C, dated 9 June 2023;
- Email from Dr B, dated 12 June 2023;
- Email from Dr D, Mentor, dated 14 June 2023;
- Emails from Dr E, Responsible Officer and Deputy Chief Medical Officer, Mid-Yorkshire Hospitals NHS Trust, dated 22 August 2023;
- Email from Dr E, dated 19 July 2023;
- PDP, dated June 2023;
- Case Review Team – Assistant Registrar decision document, dated 14 September 2023;
- Emails from Dr F, Airedale NHS Foundation Trust, dated 27 October 2023;
- Report from Dr F, Workplace reporter, dated 8 November 2023;
- Report from Dr G, Clinical & Educational supervisor, dated 8 November 2023;
- Email from Dr Haigh forwarding confirmation of attendance on Immediate Care Course, dated 7 November 2022;
- Written reflections document.

## Submissions

28. On behalf of the GMC, Ms Laura Kaye, Counsel, drew the Tribunal's attention to paragraph 164 of the Sanctions Guidance (November 2020) ('the SG'), which states:

> '*164 In some misconduct cases it may be self-evident that, following a short suspension, there will be no value in a review hearing. However, in most cases where a period of suspension is imposed, and in all cases where conditions have been imposed, the tribunal will need to be reassured that the doctor is fit to resume practice – either unrestricted or with conditions or further conditions. A review hearing is therefore likely to be necessary, so that the tribunal can consider whether the doctor has shown all of the following (by producing objective evidence):*
>
> *a they fully appreciate the gravity of the offence*
> *b they have not reoffended*
> *c they have maintained their skills and knowledge*

> *d patients will not be placed at risk by resumption of practice or by the imposition of conditional registration.'*

She submitted that the GMC's position is that Dr Haigh's fitness to practise remains impaired by reason of misconduct. She submitted that, evidentially before the Tribunal, there is a material and persistent void in this case. She submitted that Dr Haigh has been given opportunities to provide full written reflections at his first hearing and previous review hearing, and both previous Tribunals felt that written detail was a necessary part of this case. She submitted that this remains the case.

29. Ms Kaye stated that a written reflections document is usually the most probative piece of evidence to demonstrate development of full insight but, for Dr Haigh, it has not taken a detailed written form as directed by both previous Tribunals. She submitted that Dr Haigh has been able to articulate some points of insight, but it is clear that this is not fully developed with appropriate detail. She submitted that the working reflections document provided by Dr Haigh fails to address in any meaningful detail the impact of his misconduct on Patient A, nor his journey on developing insight. Ms Kaye submitted that Dr Haigh is capable of obtaining full insight, but that it is his responsibility to bring this to fruition. She submitted that Dr Haigh has fallen short in this respect.

30. Ms Kaye submitted that there is no compelling explanation as to why a full and detailed complete written document has not been provided. She stated that Dr Haigh said he had turned his attention to this in March 2023 but the reflections document provided today was created in October. She submitted that, without that documentation, and in the absence of a detailed and holistic explanation in oral evidence, Dr Haigh is not really any further on in terms of progress than in February 2023. She submitted that there have been some indications that he is on the right path, but full insight has not yet been attained. She submitted that the Tribunal cannot be satisfied that Dr Haigh has developed full insight and that there is not a risk of repetition.

31. Ms Kaye submitted that Dr Haigh has failed to adduce any evidence of written reflections of his learning in respect of his PDP, and that what is stated in that document is lacking any specificity and fails to address and have focus upon what the last Tribunal asked for. She submitted that there is no evidence of ongoing CPD since the last hearing. She stated that whilst Dr Haigh referred to a couple of sessions in a pain management clinic in his oral evidence, this is not sufficient and there is no documentation to support what he said in his oral evidence about this. She submitted that there has been no information provided about the learning from any CPD he has undertaken.

32. Ms Kaye invited the Tribunal to make a finding that Dr Haigh's fitness to practise remains impaired by reason of misconduct.

33. Dr Haigh submitted that his insight has developed and he has continued to avoid working in the area where the incidents occurred, instead focussing on his hospital career. He accepted, however, that he had not been attentive enough to the written documentation requested by the previous Tribunal and acknowledged that it would be difficult for this Tribunal to make a positive decision today given the limited evidence provided.

## The Relevant Legal Principles

34. 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.

35. 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

36. The Tribunal first considered the determination of the February 2023 Tribunal, including what was clearly set out as to what would assist a future Tribunal at a review hearing. The Tribunal considered whether Dr Haigh had demonstrated that he had reflected further and gained sufficient insight into his actions.

37. The Tribunal noted that the February 2023 Tribunal had made clear that at today's 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.

38. In considering whether Dr Haigh's insight has developed, it bore in mind his oral evidence and the reflections document provided. Although the Tribunal was of the view that there has been some development in Dr Haigh's insight, it considered that development to be limited. In particular, the evidence provided lacked detail into the impact of his actions on Patient A and on public confidence in the profession and patient safety. The Tribunal noted Dr Haigh's own admission that the reflections were incomplete.

39. The Tribunal had regard to Dr Haigh's PDP but noted that Dr Haigh has provided no written reflections on his learning in respect thereof, as suggested by the previous Tribunal.

40. The Tribunal had regard to the reports from Dr Haigh's supervisors, including the most recent ones from Dr F and Dr G, both dated 8 November 2023. The Tribunal noted that, although there were some comments about poor organisational skills in those reports, there appears to be a consensus that there are no issues with Dr Haigh's clinical knowledge and skills required to undertake his current role. It noted that Dr F had stated in his report, dated 8 November 2023, that:

'*Dr Haigh has been a valuable member of our team during his employment with us.*

*I have directly observed and others have fed back that he always behaves in a professional manner and offers a good standard of care within his remit. His rapport with patients and staff is excellent. He seeks assistance appropriately and makes appropriate decisions within the scope of his restricted practice.*'

Further, in Dr G's report, dated 8 November 2023, she stated '*We have discussed the circumstances that led to GMC referral and focussed plans to address high risk decision making on pre hospital care as this is a very different area to supervised in theatre anaesthetic practice. He has shown insight into the events and gone beyond GMC requirements and looked at chronic pain management to help him understand how these patients might present in a crisis. …*

*Clinically he has been perceived as a competent and personable trust grade doctor. He has coped with the pressures of starting a new job with work in some areas he had not had recent experience in, with no complaint and no concerns raised from the theatre or ICU MDT.*'

41. The Tribunal noted that there has been no evidence provided of ongoing CPD undertaken since the last review hearing.

42. The Tribunal went on to consider the risk of repetition. Although the Tribunal was encouraged by the positive recent reports of Dr F and Dr G, it could not be satisfied that Dr Haigh has developed sufficient insight into his actions and the reasons behind them that would sufficiently mitigate the risk in this case. Until further reflection and insight has been developed, the Tribunal was of the view that there remains a risk of repetition. The Tribunal noted that Dr Haigh had agreed that he had failed to provide sufficient evidence at this review hearing. The Tribunal was of the view that there was no compelling reason to justify this.

43. As such, this Tribunal has therefore determined that Dr Haigh's fitness to practise is impaired by reason of misconduct.

## Determination on Sanction - 01/12/2023

44. Having determined that Dr Haigh's fitness to practise is impaired by reason of misconduct, the Tribunal now has to decide in accordance with Rule 22(1)(h) of the Rules what action, if any, it should take with regard to Dr Haigh's registration.

### The Evidence

45. The Tribunal has taken into account the background to the case and the evidence received during the earlier stage of the hearing where relevant to reaching a decision on what action, if any, it should take with regard to Dr Haigh's registration.

### Submissions

46. On behalf of the GMC, Mr Shand submitted that even though the Tribunal found there to be a measure of progress, this was not sufficient to justify the lifting of the conditions. Mr Shand submitted that there remained the need for this restriction on Dr Haigh's registration.

47. Mr Shand stated that a conditional period of nine months or shorter would be appropriate and a review hearing should be directed. He submitted that if the Tribunal was mindful to direct a review hearing, at that future hearing the GMC's position could go in either direction in terms of a lesser or more serious sanction.

48. Dr Haigh submitted that he was guided by the Tribunal, and he considered a six-to-nine-month period of conditions would be appropriate.

49. Dr Haigh informed the Tribunal that his new mentor had contacted him this week to arrange a meeting. He indicated to the Tribunal that he found it difficult to progress on his reflections, but he had been meeting with his educational supervisor frequently to work on his reflections and was now aware of what was lacking.

50. In regard to a timeline of how long it would take him to write his reflections, Dr Haigh indicated that he can't put a definite answer on it, but he has better structures in place this time to try and produce that work.

51. Dr Haigh said he understood that the imposition of further conditions at the last review hearing was to allow time to develop his reflections and produce the completed CPD and if he does not complete this at the next review, the GMC could be looking at the scale for a more serious sanction.

## The Tribunal's Determination

52. The Tribunal is aware that the decision as to the appropriate sanction, if any, to impose on Dr Haigh's registration is a matter for this Tribunal alone, exercising its independent judgement. In reaching its decision, the Tribunal has taken account of the Sanctions Guidance (November 2020) ('the SG').

53. The Tribunal took into account its decision on impairment, the submissions of Mr Shand and Dr Haigh, and the documentary evidence adduced during the course of these proceedings.

54. The Tribunal recognised that the purpose of a sanction is not to be punitive, although it may have a punitive effect. The Tribunal must impose a sanction if it is required in order to protect patients, maintain public confidence in the profession, and/or meet the wider public interest. Throughout its deliberations, the Tribunal applied the principle of proportionality, balancing Dr Haigh's interests with the public interest.

55. In deciding what sanction, if any, to impose, the Tribunal reminded itself that it must consider each of the sanctions available, starting with the least restrictive, to establish which sanction is appropriate and proportionate.

### No action

56. In coming to its decision as to the appropriate sanction, the Tribunal first considered whether to conclude the case by taking no action. It reminded itself that there should be exceptional circumstances to justify taking no action where a finding of impairment has been made.

57. The Tribunal considered that there were no exceptional circumstances to justify taking no action in this case. It determined that it would be neither sufficient, proportionate nor in the public interest, to conclude this case by taking no action.

Conditions

58. The Tribunal next considered whether it would be appropriate to impose conditions on Dr Haigh's registration. It bore in mind that any conditions imposed should be appropriate, proportionate, workable and measurable. It had regard to paragraphs 81, 82, 84 and 85 of the SG which indicate the cases in which conditions might be appropriate.

59. The Tribunal noted that this was a case where conditions were deemed appropriate previously. It was satisfied that it was appropriate, necessary and proportionate to continue to impose conditions on Dr Haigh's registration. It considered that conditions could be workable and measurable and allow Dr Haigh to safely continue on his journey to return to unrestricted practice.

60. The Tribunal considered the evidence before it. It was of the view that Dr Haigh's insight has developed further since his last review hearing but was not yet complete. The Tribunal was encouraged that Dr Haigh has engaged with his clinical and educational supervisor. However, it noted that there has still been no evidence provided of the written reflections on his PDP since the last review hearing.

61. The Tribunal had regard to the current conditions in place on Dr Haigh's registration. It considered that these conditions continued to be appropriate for Dr Haigh except for the need for one variation in relation to condition 5a, which now needs to be an updated PDP.

62. Although Dr Haigh has provided a document entitled PDP for the current review, he had provided no written reflections on his learning in respect thereof, as suggested by the previous Tribunal. The Tribunal considered that an updated PDP plan, specifically with updated timelines would be useful to a future reviewing Tribunal. It determined that it was necessary for a future reviewing Tribunal to have sight of a comprehensive PDP and CPD from Dr Haigh if he wished to return to unrestricted practice. In particular, the Tribunal considered it necessary that Dr Haigh provide written outcomes on his learning on the two specific topics as outlined in condition 5a: *Clinical judgement and decision making with particular reference to risk management; Developing judgement and resilience in difficult clinical situations.*

63. The Tribunal received evidence that Dr Haigh is a clinically competent doctor who is well valued in his team and there have been no concerns raised about his clinical knowledge

and skills. Therefore, it was concerned that the longer Dr Haigh prolongs his progress, the harder it will be for him to return to unrestricted practice. It can only urge Dr Haigh to be proactive in his commitment towards progress and to avail himself of all the support available to him.

64. Given all the matters already outlined, the Tribunal determined that suspension would be disproportionate as the concerns relating to Dr Haigh's practice could be managed with the imposition of a further period of conditional registration.

Length of order

65. Having determined to impose a further order of conditions, the Tribunal considered the length of the order of conditional registration. The Tribunal determined to impose conditions for a period of six months. It bore in mind that nine-months was imposed at the last review hearing, and it considered that a longer period of time may not encourage Dr Haigh to make progress. The Tribunal considered six months was not only sufficient time but would hopefully focus Dr Haigh's attention to update his PDP, provide written reflections and undertake CPD. The Tribunal considered that this length of conditional registration struck a fair balance between the wider public interest and Dr Haigh's interests.

66. The following conditions will be published:

1 He must personally ensure the GMC is notified of the following information within seven calendar days of the date these conditions become effective:

a the details of his current post, including:

i his job title;

ii his job location;

iii his responsible officer (or their nominated deputy).

b the contact details of his employer and any contracting body, including his direct line manager;

c any organisation where he has practising privileges and/or admitting rights;

d any training programmes he is in.

2 He must personally ensure the GMC is notified:

a of any post he accepts, before starting it;

b that all relevant people have been notified of his conditions, in accordance with condition 12;

c if any formal disciplinary proceedings against him are started by his employer and/or contracting body, within seven calendar days of being formally notified of such proceedings;

d if any of his posts, practising privileges or admitting rights have been suspended or terminated by his employer before the agreed date within seven calendar days of being notified of the termination;

e if he applies for a post outside the UK.

3 He must allow the GMC to exchange information with any person involved in monitoring his compliance with his conditions.

4 a He must have a workplace reporter appointed by his responsible officer (or their nominated deputy);

b He must not work until:

i his responsible officer (or their nominated deputy) has appointed his workplace reporter;

ii he has personally ensured that the GMC has been notified of the name and contact details of his workplace reporter.

5 a He must update the existing personal development plan (PDP), with specific aims to address the deficiencies in the following areas of his practice:

- Clinical judgement and decision making with particular reference to risk management;
- Developing judgement and resilience in difficult clinical situations.

b His PDP must be approved by his responsible officer (or their nominated deputy);

c He must give the GMC a copy of his approved PDP within three months of these substantive conditions becoming effective;

d He must give the GMC a copy of his approved PDP on request;

e He must meet with his responsible officer (or their nominated deputy), as required, to discuss his achievements against the aims of his PDP;

6 a He must have an educational supervisor appointed by his responsible officer (or their nominated deputy);

b He must not work until:

i his responsible officer (or their nominated deputy) has appointed his educational supervisor;

ii he has personally ensured that the GMC has been notified of the name and contact details of his educational supervisor.

7 He must get the approval of the GMC before working in a non-NHS post or setting.

8 He must only work in specialities of Anaesthesia and Intensive Care Medicine as part of a recognised training scheme or at an equivalent supervised Trust Grade within the NHS.

9 a He must be supervised in all of his posts by a clinical supervisor, as defined in the Glossary for undertakings and conditions. His clinical supervisor must be approved by his responsible officer (or their nominated deputy);

b He must not work until:

i his responsible officer (or their nominated deputy) has appointed his clinical supervisor and approved his supervision arrangements;

ii he has personally ensured that the GMC has been notified of the name and contact details of his clinical supervisor and his supervision arrangements.

10 a He must get the approval of his responsible officer (or their nominated deputy), before working as:

i a locum;

b He must not work until:

i his responsible officer (or their nominated deputy) has confirmed approval;

ii he has personally ensured that the GMC has been notified of the approval of his responsible officer (or their nominated deputy).

11 He must have a mentor who is approved by his responsible officer (or their nominated deputy).

12 He must personally ensure the following persons are notified of the conditions listed at 1 to 11:

a his responsible officer (or their nominated deputy);

b the responsible officer of the following organisations:

i his place(s) of work, and any prospective place of work (at the time of application);

ii all his contracting bodies and any prospective contracting body (prior to entering a contract);

iii any organisation where he has, or has applied for, practising privileges and/or admitting rights (at the time of application);

iv any locum agency or out of hours service he is registered with;

v If any of the organisations listed at (i to iv) does not have a responsible officer, he must notify the person with responsibility for overall clinical governance within that organisation. If he is unable to identify this person, he must contact the GMC for advice before working for that organisation.

c his immediate line manager and senior clinician (where there is one) at his place of work, at least 24 hours before starting work (for current and new posts, including locum posts).

Review

67. The Tribunal determined to direct a review of Dr Haigh's case. A review hearing will convene shortly before the end of the period of conditional registration. The Tribunal wishes to clarify that at the review hearing, **the onus will be on Dr Haigh to demonstrate fully how he has reflected on his actions, developed insight and taken steps to remediate**. It therefore may assist the reviewing Tribunal if Dr Haigh:

- Completes his 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.

68. Dr Haigh will also be able to provide any other information that he considers will assist.

69. The Tribunal have directed to impose varied conditions on Dr Haigh's registration for a period of six months. The MPTS will send Dr Haigh a letter informing him of his right of appeal and when the direction and the new sanction will come into effect. The current order of conditions will remain in place during the appeal period.

**ANNEX A –** 10/11/2023

**Determination on adjournment and extension of current sanction**

1. Due to the lateness of the hour and there being insufficient time for the Tribunal to conclude Dr Haigh's case, the Tribunal determined that it was necessary to adjourn the hearing to reconvene at a later date. The Tribunal identified that next possible date when all three Tribunal Members were available was 1 December 2023.

2. The Tribunal noted that the current conditions on Dr Haigh's registration are due to expire on 24 November 2023. It invited submissions from parties as to whether it is necessary to extend the current order of conditions in accordance with section 35D(12)(c) of the Medical Act 1983 and Rule 22(5) of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules').

3. On behalf of the GMC, Ms Kaye submitted that the current sanction of conditions should be extended for a period of about two weeks to accommodate the re-listing of this hearing. She submitted that, given Dr Haigh's current situation, there is little to no prejudice to him for the conditions to continue for such a short period.

4. Dr Haigh submitted that it would not make any material difference to him if the conditions were extended and, as such, he would be content with any such extension.

5. The Tribunal determined that it was necessary for public protection, was in the public interest and was proportionate in this case for the order of conditions to be extended for a period of two weeks.