PUBLIC RECORD

Dates: 09/01/2023 – 27/01/2023
03/07/2023 - 06/07/2023

Medical Practitioner's name:	Dr Wael ZGHAIBE
GMC reference number:	6075240
Primary medical qualification:	MD 2000 University of Tichreen

Type of case	Outcome on facts	Outcome on impairment
New - Misconduct	Facts relevant to impairment found proved	Not Impaired

Summary of outcome

Warning

Tribunal:

Legally Qualified Chair	Mr Sean Ell
Lay Tribunal Member:	Mr John Ennis
Medical Tribunal Member:	Dr Anita Clay

Tribunal Clerk:	Ms Maria Khan

Attendance and Representation:

Medical Practitioner:	Present and represented
Medical Practitioner's Representative:	Mr Jon Holl-Allen, KC, instructed by the MDU
GMC Representative:	Mr Christopher Rose, 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 Facts - 25/01/2023

Background

1. Dr Zghaibe qualified in 2000 from the University of Tichreen, Syria. In January 2013 he started working at Milton Keynes University Hospital NHS Foundation Trust ('the Trust') in Anaesthesia and Intensive Care.

2. The allegation that has led to Dr Zghaibe's hearing can be summarised as follows: on 25 July 2018 and 18 August 2020, Dr Zghaibe failed to provide good clinical care to Patients A and B respectively. Dr Zghaibe was the anaesthetist for both patients.

Patient A

3. It is alleged that on 25 July 2018, Dr Zghaibe was part of the multidisciplinary team responsible for preparing and optimising Patient A for transfer and that he made a number of failures in respect of that patient's care. Dr Zghaibe was a locum Specialty Doctor in Anaesthesia at the time of the events and had been asked to oversee the transfer of Patient A.

4. Patient A, aged 61, suffered from morbid obesity, hypertension, asthma and obstructive sleep apnoea. He had been admitted to the Emergency Department at the Trust on 5 July 2018, unwell with abdominal pain and acute pancreatitis. His condition deteriorated and he was transferred to the Department of Critical Care ('DoCC') on 6 July 2018. Patient A required intubation under sedation and was breathing with the assistance of mechanical ventilation.

5. Patient A's health continued to be of concern. On 24 July 2018 the decision was made by the DoCC consultants to transfer Patient A, on 25 July 2018, to the Adult Intensive Care Unit at another hospital 40 miles away, for other treatment options. Dr Zghaibe was asked to oversee the transfer.

6. Whilst Patient A was being prepared for the transfer, he was connected to the Draegar Oxylog 3000 plus ('the Oxylog'), a portable ventilator. The oxygen was initially provided from a wall supply. Immediately prior to Patient A's transfer the oxygen was disconnected from the wall by Dr Zghaibe, and transferred to a portable oxygen cylinder, which was connected by a paramedic. Dr Zghaibe silenced the audible alarms on the Oxylog which had sounded, indicating the disconnection of the oxygen supply from the wall. Shortly after Patient A was moved from the bedspace his condition rapidly deteriorated, with a drop in blood pressure and un-recordable oxygen saturation. He was moved back to his bedspace and at this point it was noticed that the oxygen hose was not connected to the oxygen cylinder. Patient A suffered a cardiac arrest and despite CPR being commenced, he died.

7. The Trust carried out an internal investigation and a Serious Incident Report was compiled. The incident was put down as human error. There also followed a Coroner's Inquest during which there was no personal criticism of Dr Zghaibe.

Patient B

8. It is alleged that on 18 August 2020, Dr Zghaibe was responsible for the care of Patient B and that he made a number of failures in relation to that patient's care.

9. Patient B was a 61 year-old lady who was admitted to the Emergency Department at the Trust on 18 August 2020 with acute appendicitis and due for an emergency laparoscopic appendicectomy. By the time of the incident Dr Zghaibe was a Consultant Anaesthetist, and he was assigned to Patient B's operation.

10. As part of his pre-operative assessment with Patient B, Dr Zghaibe enquired as to whether she had had any previous complications with anaesthetics. From Patient B's responses, Dr Zghaibe mistakenly understood that she had previously had a tracheostomy.

11. In theatre, Dr Zghaibe was assisted by an allocated Operating Department Practitioner (ODP). Following the intravenous induction of anaesthesia, the ODP, under the supervision of Dr Zghaibe, attempted to intubate Patient B but was unable to do so. This was then carried out by Dr Zghaibe, who erroneously inserted the oxygen pipe into Patient B's oesophagus instead of her trachea. Patient B started to become hypoxic and a working diagnosis of anaphylaxis was proposed by Dr Zghaibe.

12. Patient B suffered a cardiorespiratory arrest as a result of the failure to recognise and correct the oesophageal intubation. The fact that the tube had been incorrectly sited was identified by another Consultant Anaesthetist 11 minutes after the emergency call was made. The proposed surgery was abandoned and Patient B was transferred to intensive care. It became apparent that she had suffered a severe hypoxic ischaemic brain injury.

13. A decision was taken with Patient B's next-of-kin to discontinue active support and Patient B died on the 23rd August 2020. An Incident Investigation Report was compiled by the Trust.

14. Concerns were raised with the GMC on 11 December 2020 by Dr C, Consultant Physician and Medical Director at the Trust, who submitted a referral in relation to Dr Zghaibe's fitness to practise resulting from the two incidents.

The Outcome of Preliminary Applications

15. On 9 January 2023, prior to the opening of this hearing, Mr Rose, Counsel, on behalf of the GMC, raised as a preliminary matter under Rule 17(2)(a) of the GMC (Fitness to Practise Rules) 2004 as amended ('the Rules'), the inability of the GMC to commence its case due to XXX a witness and applied to adjourn the hearing until the witness was XXX to give evidence. The Tribunal took into account that there was no objection raised on behalf of Dr Zghaibe to the application and was satisfied that it was not in the public interest to proceed, given the importance of the witness's evidence to the Allegation. The Tribunal granted the application to adjourn the hearing until 09:30 on 12 January 2023. The Tribunal's full decision on the application is included at Annex A.

16. On 12 January 2023, the Tribunal granted the GMC's applications, made pursuant to Rule 17(6) of the Rules, for amendments to the Allegation. Mr Rose, on behalf of the GMC, asked the Tribunal to amend the Allegation to correct a number of typographical errors in respect of the numbering, as well as a change in the date in the stem of paragraph 1, and the addition of the words, *'failed to'* to the stem of paragraph 2j. There was no objection raised on behalf of Dr Zghaibe to any of the amendments. The Tribunal was satisfied that the amendments could be made without any injustice to the doctor and so agreed to them. The amendments were then included in the Allegation, as set out in full below.

The Allegation and the Doctor's Response

17. The Allegation made against Dr Zghaibe is as follows:

That being registered under the Medical Act 1983 (as amended):

1. On ~~24~~25 July 2018 you were part of the multidisciplinary team responsible for preparing and optimising Patient A for transfer, and you failed to:
   Amended under Rule 17(6)

   a. check functionality of the transport ventilator after the change of oxygen supply;
      To be determined

   b. respond appropriately to the alarms that were generated by the transport ventilator;
      To be determined

   c. identify the markers of the absence of ventilatory support before the point of secondary cardiac arrest, namely:

i. Patient A's oxygen saturation falling;
To be determined

ii. Patient A further decompensating from a cardiovascular perspective to the point of irreversible cardiac arrest;
To be determined

d. in the alternative, record your actions or omissions, as outlined at paragraphs 1.~~b~~a to 1.~~d~~c
Amended under Rule 17(6)
To be determined

2. On 18 August 2020, you were responsible for the care of Patient B and you:

a. failed to obtain an adequate history and/or undertake an adequate pre-operative assessment, including:

i. any American Society of Anesthesiologists background health classification;
To be determined

ii. any classification as to urgency under National Confidential Enquiry into Perioperative Death;
To be determined

iii. the weight and height of Patient B;
To be determined

iv. results of pre-operative investigations;
To be determined

v. the length of time since food or fluids had been taken;
To be determined

vi. whether Patient B had any symptoms of, or had been exposed to individuals with COVID-19;
To be determined

vii. exploring Patient B's previous tracheostomy;
To be determined

viii. whether there was any inspiratory stridor;
To be determined

b. failed to communicate your opinion that Patient B had undergone a previous tracheostomy to other healthcare professionals;
To be determined

c. inappropriately requested Operating Department Practitioner C attempt introduction of the endotracheal tube;
Admitted and found proved

d. completed an oesophageal intubation instead of intubating the trachea;
To be determined

e. inappropriately diagnosed Patient B's complications as anaphylaxis;
To be determined

f. failed to appropriately respond to your perceived diagnosis of anaphylaxis, including to request:

i. intravenous fluids;
To be determined

ii. hydrocortisone;
To be determined

iii. antihistamine agents;
To be determined

g. failed to correctly diagnose oesophageal intubation;
Admitted and found proved

h. continued to discount the correct diagnosis of oesophageal intubation as serious complications occurred, including:

i. progressive hypoxia;
To be determined

ii. cardiovascular dysfunction;
To be determined

iii. cardiac arrest;
To be determined

i. failed to consider the alleged previous tracheostomy as a factor in Patient B's complications;
To be determined

j. in the alternative, failed to record your actions or omissions as outlined at paragraphs: Amended under Rule 17(6)

i. 2.a;
To be determined

ii. 2.b;
To be determined

iii. 2.g;
To be determined

iv. 2.~~j~~i.
Amended under Rule 17(6)
To be determined

And that by reason of the matters set out above your fitness to practise is impaired because of your misconduct.

The Admitted Facts

18. At the outset of these proceedings, through his counsel, Mr Holl-Allen KC, Dr Zghaibe made admissions to some paragraphs and sub-paragraphs of the Allegation, as set out above, in accordance with Rule 17(2)(d) of the Rules. In accordance with Rule 17(2)(e) of the Rules, the Tribunal announced these paragraphs and sub-paragraphs of the Allegation as admitted and found proved.

The Facts to be Determined

19. In light of Dr Zghaibe's response to the Allegation made against him, the Tribunal is required to determine whether aspects of Dr Zghaibe's standard of care delivered to Patients A and B fell below the standard expected of him.

Witness Evidence

20. The Tribunal received evidence on behalf of the GMC in the form of a witness statement from the following witness who was not called to give oral evidence: Dr C, who provided a statement dated 31 May 2022.

21. Dr Zghaibe provided his own witness statement, dated 14 September 2022, and also gave oral evidence at the hearing.

Expert Witness Evidence

22. The Tribunal received evidence on behalf of the GMC from Dr D, Consultant in Anaesthesia and Intensive Care at The General Infirmary at Leeds. Dr D has over 30 years' experience in this field. Dr E, Consultant Anaesthetist at Nottingham University Hospitals NHS Trust, provided evidence on behalf of Dr Zghaibe. Dr E is the immediate Past-President of Council of the Association of Anaesthetists. Both expert witnesses gave oral evidence at the hearing. The Tribunal had regard to the following reports:

- Expert report of Dr D in respect of Patient A, dated 9 September 2021;
- Expert report of Dr D in respect of Patient B, dated 14 September 2021
- Expert report of Dr E in respect of Patient A and Patient B, dated 31 August 2022

- Joint expert report of Dr D and Dr E in respect of Patient A, dated 10 December 2022; and
- Joint expert report of Dr D and Dr E in respect of Patient B, dated 10 December 2022.

23. The expert reports assisted the Tribunal in its understanding of the functioning mechanism of the Oxylog, and also its understanding of whether, and how, Dr Zghaibe's actions and/or omissions during his care of both patients could have fallen below, or seriously below, the standard expected of a reasonably competent anaesthetist.

Documentary Evidence

24. The Tribunal had regard to the documentary evidence provided by the parties. This evidence included but was not limited to:

- Fitness to Practise Referral Form, dated 11 December 2020;
- The Trust Serious Incident Report regarding Patient A, dated 4 January 2019;
- The Trust Incident Investigation Report regarding Patient B, dated 10 December 2020;
- Dr C's correspondence with Practitioner Performance Advice, various dates;
- Coroner's Report into the death of Patient B, dated 8 July 2021;
- Letter submitted by Dr C to the GMC providing an update on the legal claim against the Trust in respect of Patient A and the Coronial Inquest into Patient B, dated 20 April 2021;
- Image of the Draegar Oxylog 3000 plus;
- Videos of the Draegar Oxylog 3000 including demonstration of the display and alarm mechanisms, prepared by Dr D;
- Patient A's medical records; and
- Patient B's medical records.

The Tribunal's Approach

25. In reaching its decision on facts, the Tribunal has borne in mind that the burden of proof rests on the GMC and it is for the GMC to prove the Allegation. Dr Zghaibe does not need to prove anything. The standard of proof is that applicable to civil proceedings, namely the balance of probabilities, i.e. whether it is more likely than not that the events occurred.

26. The Tribunal reminded itself that the inherent probability or improbability of an event is a matter which can be taken into account when weighing the probabilities and in deciding whether the event occurred. Where an event is inherently improbable, better evidence may be required to find it proved. That however goes to the quality of evidence rather than the standard of proof. There is no logical or necessary connection between seriousness and probability, and thus it is not the case that *"the more serious the allegation the more cogent the evidence needed to prove it"; Byrne v General Medical Council* [2021] EWHC 2237 (Admin) (10 August 2021).

27. The Tribunal bore in mind it must consider each paragraph of the Allegation separately in order to be able to make individual findings. However, if one part of the

Allegation is found proved, it would be entitled to take account of that, when considering propensity to act as alleged in other parts of the Allegation. In reaching a conclusion on each paragraph separately, the Tribunal is entitled, in determining whether or not each paragraph is proved, to have regard to relevant evidence in regard to any other paragraph and may therefore consider the evidence in the round.

28. In assessing the credibility of witnesses, the Tribunal reminded itself that it should not assess credibility exclusively on the demeanour of the witness when giving their evidence, but their veracity should be tested by reference to objective facts proved independently in the evidence, in particular by reference to the documents in the case. The Tribunal noted that, when considering the evidence of any witness in this case, it should also bear in mind the extent to which the passage of time may have affected the memory of a witness. It would be open to the Tribunal to accept the evidence of a witness on one head of charge but not another, provided that there was not an overall finding that the witness cannot be relied upon generally.

29. The Tribunal took into account it was entitled, where appropriate, to draw proper inferences - to come to common sense conclusions based upon the evidence which it accepted as reliable; but it must not speculate. Similarly, the Tribunal should not speculate about what other evidence there might have been.

The Tribunal's Analysis of the Evidence and Findings

30. The Tribunal has considered each outstanding paragraph of the Allegation separately and has evaluated the evidence in order to make its findings on the facts.

Patient A

Paragraph 1a

31. The GMC relied on the evidence of Dr D that the operation of the Oxylog's various alarms and warnings, meant that if Dr Zghaibe checked the functionality of the ventilator, as he claimed, and there were no warning signs and no subsequent activation of alarms, Dr Zghaibe's check must have taken place before the oxygen hose was disconnected from the wall supply. Mr Rose submitted that scenario was consistent with the concession made by Dr Zghaibe during the Serious Incident Investigation. As such he submitted, there was no check of the ventilator functionality by Dr Zghaibe after the change of oxygen supply.

32. Mr Holl-Allen relied on the evidence of Dr E, that it was possible a temporary reconnection of the oxygen supply took place and as such that would have the effect of restoring the pressure waveform on the Oxylog and any capnograph trace. Dr Zghaibe gave evidence that his usual practice was to check the ventilator following confirmation of reconnection of the oxygen supply. Mr Holl-Allen submitted there was no reason why he would not have followed that practice on this occasion. As such, having been informed by the paramedic that the oxygen supply had been changed, Dr Zghaibe would have checked the Oxylog and been reassured.

33. The Tribunal considered the opinions expressed by the experts. Although there were areas where they agreed, there were areas where their evidence diverged. Notably as to whether there could have been a temporary connection to the portable oxygen cylinder. The Tribunal preferred the evidence of Dr E on this point. He was able to provide the Tribunal with personal examples of where he had seen similar situations occur. The Tribunal was not persuaded by the submission made by Mr Rose that as Dr E had not seen this specifically with the Oxylog and a cylinder, his evidence on this point could not be relied upon. The Tribunal noted that the same types of connections were used, whether portable or for a wall, and that the Serious Incident Report did not exclude the possibility of the hose having been temporarily connected. The Serious Incident Report notes that on discovery of the lack of an oxygen connection, *"The hose was not completely out but loose"*, and the Tribunal considered this consistent with Dr E's opinion as to a temporary connection.

34. The Tribunal heard from both experts on the functionality of the various alarms and warnings displayed on the Oxylog. Although both experts are highly qualified anaesthetists, the Tribunal concluded neither could be considered an expert on the Oxylog. Both experts' experience of the machine was achieved through their use, Dr D was the more experienced, using the machine on a regular basis, whilst Dr E used it infrequently. Neither expert had received any formal training on the machine. Both had familiarised themselves with the manual to try and assist the Tribunal. There was disagreement between them on what would happen if the alarm was silenced, if there was a temporary reconnect of oxygen and whether the machine automatically reset itself on connection of an oxygen supply.

35. The Tribunal reminded itself that the burden of proof is on the GMC. It was not satisfied on the evidence before it that the function of the Oxylog was such that a temporary connection would not have reset the machine or that on a subsequent disconnection of the oxygen supply, the alarm would have re-sounded if it had previously been silenced and the two minutes thereafter had not been reached.

36. The Tribunal considered the evidence of Dr Zghaibe. It found him to be a credible witness, someone willing to make concessions where appropriate, for example about limitations in his knowledge of the Oxylog and his recollection of events. If he was uncertain, he would say so. The Tribunal noted the view expressed by the Coroner in the Inquest into Patient B's death, where it was said of Dr Zghaibe that:

> *"'I should say that in respect of Dr Zghaibe's evidence I found he was candid and honest. I am afraid that in my experience of hearing several thousand Inquests that that is rare. I am grateful for the way he conducted himself'."*

37. The Tribunal shared a similar view to the coroner and found Dr Zghaibe to be both a candid and honest witness as to the events. It therefore accepted Dr Zghaibe's evidence as to his usual practice. It took into account that Dr Zghaibe had formed patterns of behaviour and that he was not new to transferring patients. He had been asked to cover due his experience and the Tribunal considered it was unlikely that he would have unplugged the Oxylog,

silenced the alarms, and having confirmed the connection with the paramedic not then checked the functionality. The Tribunal noted Dr Zghaibe's oral evidence that he had checked: functionality; waveform, *"I checked the trace on the ventilator";* and the oxygen after reconnection, *"I silenced the alarm and checked the trace"*. It also noted that he had recorded doing this in his retrospective note of what had occurred, shortly after the patient died.

38. The Tribunal accepted Dr Zghaibe's explanation that the concession that he made during the Serious Incident Investigation, that he must not have checked, was predicated on the Trust's interpretation of the report provided by the manufacturer of the Oxylog. He had not read that report at that time and relied upon what he had been told. He was unaware of Dr E's opinion, at that time, that temporary connections could occur and would appear to show, on the machine, as if the connection was made.

39. The Tribunal was satisfied, on the balance of probabilities, that Dr Zghaibe did check the functionality of the transport ventilator after the change of oxygen supply. Given the ambulance transfer checklist required the ventilator to be checked every five minutes, in the absence of a new alarm, or a specific indication of a problem with ventilation, the Tribunal was satisfied that it was reasonable for Dr Zghaibe not to have checked the functionality of the ventilator again in the short period that followed.

40. Accordingly, the Tribunal found paragraph 1a of the Allegation to be not proved.

Paragraph 1b

41. Both experts accept that Dr Zghaibe silencing the power and oxygen supply audible alarms immediately after disconnection from the mains power and wall oxygen supply, and before reconnection of the oxygen supply by the paramedic, was reasonable. There is no evidence that the audible alarm re-sounded, so as to alert Dr Zghaibe to any issue before Patient A was returned to the bedspace and the disconnection was discovered.

42. The Tribunal noted Dr Zghaibe's evidence that the Oxylog was placed underneath Patient A's trolley due to Patient A's size and the lack of space on the trolley to accommodate it. It was, he explained, more important to have the monitor stack on the trolley than the Oxylog. The Tribunal has found that Dr Zghaibe had checked the functionality of the machine after the change in oxygen supply and had been satisfied that there was a connection. The Tribunal considered it implausible that Dr Zghaibe would not have followed up on the written warnings on the Oxylog if they were still displayed and he had seen them. It noted that, as recorded in the Serious Incident Report, no attempt was made to reset the alarms, which the Tribunal considered supportive of its conclusion that the messages were not displayed when Dr Zghaibe checked the machine.

43. It is unclear at what point the oxygen hose became disconnected. In the absence of a second audible alarm, the Tribunal is satisfied that Dr Zghaibe did not fail to respond appropriately to the alarms that were generated by the Oxylog.

44. Accordingly, the Tribunal found paragraph 1b of the Allegation to be not proved.

Paragraph 1c(i)-(ii)

45. Dr D in his evidence to the Tribunal doubted the merit of the Consultant Anaesthetist's decision to transfer Patient A. He observed that were a number of simultaneous complications of Patient A's management. It would, in his opinion, have been more appropriate for the Consultant Anaesthetist to have been in charge of the transfer, than Dr Zghaibe.

46. The medical records showed that in the hour leading up to his transfer, Patient A had a number of episodes of instability. There were occasions during this period when his blood pressure fell and as recorded by Dr Zghaibe in his notes, the oxygen saturation on the monitor was poor. During this time Patient A required repeated medication to maintain his blood pressure. Dr D in his report described the difficulties in preparing Patient A for transfer as being *"multiple challenges in ventilation, in maintaining a satisfactory blood pressure, and in recording a reliable oxygen saturation reading and invasive blood pressure"*.

47. Shortly before Patient A was moved from the bedspace Dr Zghaibe asked for a blood gas result to be obtained, for a baseline reading. The results were provided to Dr Zghaibe as Patient A had started to move away from the bedspace. On catching up with the trolley near the doors to the department, Dr Zghaibe was informed that Patient A was not holding his blood pressure. The Tribunal accepts his evidence that no concerns were expressed about lack of ventilation until Patient A had returned to the bedspace and the connection issue was discovered by the Consultant. Dr Zghaibe recorded in his notes that Patient A's blood pressure was worryingly low at 60-70 falling to 40 systolic, with a low saturated oxygen reading, and he therefore focused on the monitor displaying blood pressure, pulse rate and oxygen saturation readings. He gave immediate drug treatment for the low blood pressure in the form of boluses of metaraminol and noradrenaline while directing that Patient A be moved back to the bedspace.

48. Dr D in his evidence was critical of the approach taken by Dr Zghaibe. He opined that a fuller assessment of the cause of the collapse should have taken place at the doors to the department and before the administration of medication. In particular that Dr Zghaibe should have identified Patient A's difficulties as the result of an absence of ventilation. Dr E's evidence was that he would have acted as Dr Zghaibe did and that it would be appropriate for a doctor to deal with matters in parallel rather than in series. It was not, he opined, inappropriate to have started to treat the blood pressure whilst moving the patient back to the bedspace, given the proximity of Patient A to the bedspace and the additional medical team support available there.

49. Dr D opined that the primary or sole cause of the reported fall in blood pressure was a failure of ventilation and Dr Zghaibe should have identified it as such. Dr E in his evidence offered a second explanation, namely that the fall in blood pressure was attributable to a

primary cardiovascular problem similar to that which Patient A had experienced in the period immediately before transfer from the bedspace. He also observed that it could have been a combination of the two. Dr E pointed out to the Tribunal Dr Zghaibe's observation that Patient A had a heart rate of 130bpm immediately before the cardiac arrest, which he opined was more in keeping with a primary cardiovascular problem than with a ventilatory failure. The Tribunal preferred the evidence of Dr E that Patient A's presentation was consistent with a cardiovascular cause.

50. The Tribunal was therefore not satisfied that the drop or loss in reading of the oxygen saturation, or Patient A's decompensating could only be explained as markers of the absence of ventilatory support. Instead, both were also consistent with a primary cardiovascular problem similar to that which Patient A had already suffered. Given the proximity to the bedspace, the Tribunal concluded it was appropriate for Dr Zghaibe to have returned the patient there whilst treating the falling blood pressure on the way. The Tribunal has already determined Dr Zghaibe had satisfied himself as to the functionality of the ventilator and there had been no subsequent alarm to raise the issue of a problem with the ventilation. Accordingly, the Tribunal concluded that Dr Zghaibe had identified the markers of falling oxygen saturation and Patient A decompensating, but that it was not a failure in the circumstances he faced, to not attribute them to the absence of ventilatory support.

51. The Tribunal therefore found paragraph 1c of the Allegation to be not proved in its entirety.

Paragraph 1d

52. The Tribunal had regard to the detailed note made retrospectively by Dr Zghaibe, on 25 July 2018 in respect of what had happened with Patient A. Within the note he records that he had checked the Oxylog functionality. Dr Zghaibe also recorded changes in Patient A's blood pressure, as well as the low oxygen saturation readings, indicators of Patient A's further decompensation.

53. The Tribunal noted that the absence to record the response to the Oxylog alarms was not addressed directly by Dr D and Dr E in their joint report. The Tribunal however had regard to Dr E's evidence, which it accepts, that this was not a failure. The notes recorded that a change from the wall supply to the cylinder had been made. Given both experts accept it was not inappropriate to have silenced the alarms, the Tribunal was of the view it was not necessary to have explicitly recorded that it had been done in the Patient's notes.

54. The Tribunal was satisfied that the content of the retrospective note prepared was an adequate record of Dr Zghaibe's actions or omissions as outlined in paragraph 1d of the Allegation.

55. Accordingly, the Tribunal found paragraph 1d of the Allegation to be not proved in its entirety.

Patient B

Paragraph 2a(i)-(v)

56. The Tribunal was provided with Dr Zghaibe's anaesthetic record relating to his pre-operative assessment of Patient B. Although the information relating to these charges was not added to that pro-forma by Dr Zghaibe, neither expert considered it mandatory for Dr Zghaibe to have done so. Dr D conceded in his evidence that the information was either recorded elsewhere, self-evident from the nature of the emergency or its absence did not amount to a culpable failure. Dr E agreed. The Tribunal accepted the evidence of both experts.

57. Accordingly, the Tribunal found paragraph 2a(i)-(v) of the Allegation to be not proved.

Paragraph 2a(vi)

58. The Tribunal had regard to the timing of Patient B's proposed operation in relation to COVID-19 and noted that although PCR tests were being used in the Trust at the time, there was a significant delay for the results to come through. It accepted the view of the experts that Patient B's need for emergency surgery outweighed the need to wait for the PCR test results to be returned.

59. Dr Zghaibe accepted in his evidence that he had not asked questions of Patient B about COVID-19. He explained to the Tribunal that Patient B would have been asked those questions on her admission. When he saw Patient B she had already had a PCR test and was awaiting the results. The Trust's policy at that time was to assume that each patient was Covid positive unless proven otherwise and staff used appropriate personal protective equipment on that basis. The Tribunal noted that as part of his pre-operative assessment Dr Zghaibe had assessed Patient B's respiratory system (believed at the time to be the major indicator of COVID-19), and recorded this.

60. Given the above the Tribunal was satisfied that it was not necessary for Dr Zghaibe to have made further enquiries of Patient B as to her potential exposure to COVID-19.

61. Accordingly, the Tribunal found paragraph 2a(vi) of the Allegation to be not proved.

Paragraph 2a(vii)

62. The Tribunal noted that there is no evidence in Patient B's medical records or during the post mortem that she had ever had a tracheostomy. Dr Zghaibe accepted in his evidence that he had misunderstood Patient B. He had, when speaking to her, sought to establish when and in what circumstances the assumed tracheostomy had been performed (brain surgery seven years previously) and whether she had had any difficulties, in particular difficulties with breathing, since the tracheostomy.

63. The Tribunal noted that in his witness statement, Dr Zghaibe wrote, *'Further assessment of any relevance of a previous tracheostomy would take place on initial ventilation and intubation'.* During his evidence to the Tribunal, he explained that this was perhaps poorly worded and that he had not meant to imply that his assessment of the tracheostomy was incomplete before intubation started. He explained the apparent ease with which he intubated the patient seemed to confirm his pre-operative assessment that there was no issue due to a previous tracheostomy. The Tribunal accepted this explanation.

64. The Tribunal considered the conflicting evidence of Dr D, who opined that more questions should have been asked of Patient B in relation to the presumed tracheostomy, and that of Dr E who was of the opinion that enough had been asked. It also considered the GMC's submission that as Dr Zghaibe had arrived at an incorrect conclusion, it followed that he could not have explored the tracheostomy adequately.

65. Dr D opined that further questions should have been asked of Patient B, in particular, how long the tracheostomy had been in for; why it had been required; when it had been taken out; whether any complications had arisen from having it; whether intubation had been required following its removal; and whether Patient B had experienced any inspiratory problems since then. Dr E considered these questions to be unnecessary. Neither expert referred the Tribunal to any guidelines that set out the information required to assess a past tracheostomy prior to proceeding with anaesthesia.

66. Dr Zghaibe was asking questions of Patient B about any previous tracheostomies in his pre-operative assessment. The Tribunal took into consideration that Patient B was unwell and, as noted in her initial surgical notes, in pain. The Tribunal considered that the further questions were unnecessary, given Dr Zghaibe had sought the information most relevant to his risk assessment. The Tribunal therefore accepted Dr E's evidence on this point. It was not satisfied that in reaching an incorrect conclusion it must follow that the assessment was inadequate.

67. Accordingly, the Tribunal found paragraph 2a(vii) of the Allegation to be not proved.

Paragraph 2a(viii)

68. The Tribunal considered the conflicting opinions of the experts. Dr D opined that it was necessary for Dr Zghaibe to have properly assessed Patient B for an inspiratory stridor. Dr E was of the opinion that Dr Zghaibe's assessment was adequate. The Tribunal preferred Dr E's evidence on this point. It was of the view that it was not necessary for Dr Zghaibe to ask a patient presenting with acute abdominal issues, in an emergency situation, to be taking deep breaths so as to assess for an inspiratory strider. The Tribunal was satisfied it was sufficient for Dr Zghaibe to ask, as he did, Patient B if she had experienced any breathing difficulties and there was no reason to doubt the answers that she gave. Furthermore, Dr Zghaibe observed that there was no indication of any difficulties when Patient B had been answering his questions.

69. The Tribunal therefore concluded that Dr Zghaibe assessment as to whether or not Patient B had an inspiratory strider was adequate in the circumstances.

70. Accordingly, the Tribunal found paragraph 2a(viii) of the Allegation to be not proved.

Paragraph 2b

71. The Tribunal noted that Dr Zghaibe recorded on Patient B's anaesthetic record that he believed she had undergone a previous tracheostomy. It accepted Dr Zghaibe's evidence that he raised Patient B's previous tracheostomy during the WHO meeting that took place just before the surgery commenced. As such his colleagues would have been aware of the tracheostomy. Dr E opined that having raised the tracheostomy at the WHO briefing, it would not have been necessary to mention it again unless Patient B's complications had persisted following a check, which did not happen, of the siting of the intubation. The Tribunal accepted Dr E's evidence on this point.

72. Accordingly, the Tribunal found paragraph 2b of the Allegation to be not proved.

Paragraph 2d

73. Dr Zghaibe accepts that he completed an oesophageal intubation instead of intubating the trachea. He did not however accept that this was a failing. Both experts agreed that oesophageal intubation instead of intubating the trachea was not a failure in itself; indeed, it is quite common.

74. Mr Rose submitted that the allegation was a simple one, factually whether Dr Zghaibe carried out an oesophageal intubation instead of intubating the trachea. It was not suggested by the GMC that this was of itself a failure and the allegation was not put in that way. Mr Holl-Allen explained to the Tribunal that the denial of the charge had always been that the oesophageal intubation itself was not a failure. It was accepted that having not identified it was an oesophageal intubation was a failing. Mr Holl-Allen informed the Tribunal that there would be no objection from Dr Zghaibe to the Tribunal finding as a fact that he had carried out an oesophageal intubation instead of intubating the trachea. It was something he had always accepted.

75. Accordingly, the Tribunal found paragraph 2d of the Allegation to be proved.

Paragraph 2e

76. The Tribunal accepted the evidence of both experts that the absence of a capnograph trace should have only pointed to an oesophageal intubation, something that Dr Zghaibe accepts. Mr Holl-Allen submitted that paragraph 2e must mean more than failing to identify the correct diagnosis of oesophageal intubation and instead that the incorrect diagnosis of anaphylaxis must be shown to be inappropriate of itself. Mr Rose on behalf of the GMC submitted that such an argument cannot succeed on the basis that even a reasonable diagnosis of anaphylaxis must amount to a culpable failure if it is entirely dependent on a

failure to properly identify the presence of oesophageal intubation. The Tribunal accepted the submissions made by Mr Rose.

77. The Tribunal noted Dr D's opinion that no capnograph trace was incompatible with a diagnosis of anaphylaxis and that Patient B's presenting symptoms should have brought Dr Zghaibe back to his failure to intubate the trachea. It noted the evidence of Dr E about the many different ways that anaphylaxis can present, including that in a very limited number of cases no capnograph trace is the presenting condition. However, Dr E opined that no capnograph trace should point a practitioner immediately to an oesophageal intubation. The Tribunal considered the collapse in Patient B's capnograph trace immediately after intubation to be relevant to the need for Dr Zghaibe to have considered whether the intubation was the cause, given the known link between oesophageal intubation and a lack of capnograph trace, rather than anaphylaxis.

78. From the ongoing loss of capnograph trace and reduction in oxygen saturation it should have been apparent to Dr Zghaibe that there was no firm basis for his diagnosis of anaphylaxis. The signs instead pointed much more clearly to a failure in intubating the patient. The Tribunal accepts Dr E's evidence that it was necessary for Dr Zghaibe to have taken a step back, kept an open mind and reconsidered matters. Had he done so, the Tribunal is satisfied that the cause of Patient B's symptoms, oesophageal intubation, would have become obvious. As such the diagnosis of anaphylaxis was inappropriate.

79. Accordingly, the Tribunal found paragraph 2e of the Allegation to be proved.

Paragraph 2f(i)-(iii)

80. The Tribunal had regard to Patient B's medical records and the Incident Investigation Report in relation to the order that events occurred in, and at what time intervals. It ascertained that at 14:55 on 18 August 2020, Rocuronium was administered to Patient B and there then followed a period of 60-90 seconds of manual ventilation by face mask followed by the ODP's unsuccessful attempt at intubation.

81. The Tribunal took into account that the events occurred in a short space of time. The Tribunal noted that as complications occurred, Dr Zghaibe responded appropriately to his perceived diagnosis of anaphylaxis. It was not satisfied that the records bore out Dr D's criticism of significant and culpable delay in treating Patient B for anaphylaxis. The Tribunal accepted Dr E's evidence that the appropriate treatments were given without any delay and that Dr Zghaibe had responded quickly to the initial concerns and prioritised correctly with adrenaline and intravenous fluids. The records show that a request for adrenaline to be given and the obtaining of additional intravenous access occurred before Patient B went into cardiac arrest at 15:00. Patient B received intravenous fluids in a total volume of 1300ml from 15:00 until 15:14.

82. The Tribunal preferred the evidence of Dr E that both hydrocortisone and antihistamines are second line treatments for anaphylaxis and as such it was not necessary for them to have been requested and given immediately.

83. The Tribunal was not satisfied on the evidence that Dr Zghaibe failed to respond appropriately to his perceived diagnosis of anaphylaxis.

84. Accordingly, the Tribunal found paragraph 2f(i)-(iii) of the Allegation to be not proved.

Paragraph 2h(i)-(iii)

85. The Tribunal took into account Dr D's opinion that progressive hypoxia, cardiovascular dysfunction and cardiac arrest, in conjunction with a flat trace on the capnograph should have been a clear indication that an oesophageal intubation had been carried out. It also took into account Dr E's explanation of how in this situation, Dr Zghaibe was exhibiting human factors such as *'confirmation bias'* and *'task fixation'*. In addition, the Tribunal noted Dr E's evidence that oesophageal intubation, and the lack of awareness of it as a possibility, was a continuing problem among anaesthetists. There was even a campaign in place to raise awareness, with the slogan, *'no trace, wrong place'* but this message was not yet embedded.

86. The Tribunal then considered that further compounding Dr Zghaibe's rigidity of thinking was that he believed he had a *'Grade 1'* view during intubation and that it had been an easy intubation. Dr Zghaibe did not dispute that one of the Anaesthetic Registrars may have raised the possibility of an oesophageal intubation with him, although he does not remember it directly. Given the specific response the registrar reported they received from Dr Zghaibe, that he had had a *'Grade 1'* view and therefore oesophageal intubation was not a possibility, the Tribunal was satisfied it was more likely than not the registrar did raise with Dr Zghaibe the possibility of an oesophageal intubation as the cause of Patient B's presentation.

87. Having heard from both experts the Tribunal was satisfied that the immediate loss of capnograph trace, which continued notwithstanding the ability to ventilate Patient B, along with the cardiovascular dysfunction and cardiac arrest were obvious markers of oesophageal intubation. Those features were sufficient for the registrar to raise the possibility of oesophageal intubation with Dr Zghaibe as the cause of Patient B's condition. As Dr Zghaibe now accepts, it was necessary to step back and reconsider the situation, and had he done so he would have appreciated that the correct diagnosis was one of oesophageal intubation.

88. The Tribunal therefore concluded that Dr Zghaibe did continue to discount the correct diagnosis as serious complications occurred including progressive hypoxia, cardiovascular dysfunction and cardiac arrest, owing to his unwillingness to question that he had performed a tracheal intubation.

89. According, the Tribunal found paragraph 2h(i)-(iii) of the Allegation to be proved in its entirety.

Paragraph 2i

90. The Tribunal accepted Dr Zghaibe's evidence that he believed he had performed a satisfactory tracheal intubation as a result of which he mistakenly diagnosed Patient B as suffering from anaphylaxis.

91. The Tribunal took into account Dr E's evidence that the previous tracheostomy could only have been a relevant consideration in Patient B's complications if the tube, having correctly passed between the vocal cords into the trachea, had then passed through a section of the posterior wall of the trachea weakened by the assumed tracheostomy and into the oesophagus. Dr E explained to the Tribunal this complication, although recognised, is exceedingly rare. It is not something he has come across. Dr D opined it was something that Dr Zghaibe should have considered.

92. The Tribunal was of the view that given Patient B's symptoms Dr Zghaibe, should have considered the possibility of the tracheostomy being a factor, especially as he was certain that he had correctly intubated Patient B. The Tribunal concluded that as a result of his fixation on his diagnosis of anaphylaxis, Dr Zghaibe did not stop to consider checking the intubation at any point, despite Patient B's progressive deterioration. Had he done so it would have been apparent that the presumed previous tracheostomy could have been a factor in Patient B's complications and was therefore something that Dr Zghaibe should have considered. Although rare the tube passing through a weakened posterior wall was a possible factor and the Tribunal accepted Dr D's evidence that any competent practitioner at consultant level would automatically consider the possibility of a primary airway problem in a patient with a previous tracheostomy who became difficult to ventilate and increasingly hypoxic after intubation. The potential relevance of a previous tracheostomy to Dr Zghaibe was illustrated by the fact that he recorded this during his pre-operative assessment of Patient B under *'airway assessment'*.

93. Accordingly, the Tribunal found paragraph 2i of the Allegation to be proved.

Paragraph 2j(i)

94. The Tribunal took into account that neither expert was critical of the manner in which Dr Zghaibe obtained Patient B's history and undertook the pre-operative assessment and that, bar the height of Patient B, all the required information had been adequately documented elsewhere. No evidence was put forward by the GMC to show there was an obligation for Dr Zghaibe to record information in more than one document and the Tribunal therefore concluded that Dr Zghaibe's record keeping in respect of Patient B's history and his pre-operative assessment was adequate. Dr D was not critical that Patient B's height had not been measured or recorded.

95. Accordingly, The Tribunal found paragraph 2j(i) of the Allegation to be not proved.

Paragraph 2j(ii)

96. The Tribunal considered its earlier finding that Dr Zghaibe had communicated his opinion about Patient B's tracheostomy during the WHO meeting. The tracheostomy was noted on the anaesthetic record. The Tribunal noted there was no record of the WHO briefing.

97. The Tribunal was satisfied that it was not a failure for Dr Zghaibe not to have recorded what he said during the course of the WHO briefing. The relevant information, that Dr Zghaibe believed the patient had undergone a previous tracheostomy, was recorded in Patient B's anaesthetic record.

98. Accordingly, the Tribunal found paragraph 2j(ii) of the Allegation to be not proved

Paragraph 2j(iii) and (iv)

99. Dr Zghaibe admitted paragraph 2g, and the Tribunal found paragraph 2i to be proved, therefore the Tribunal found paragraphs 2j(iii) and (iv) of the Allegation to be not proved as they were pleaded as alternatives.

The Tribunal's Overall Determination on the Facts

100. The Tribunal has determined the facts as follows:

1. On ~~24~~25 July 2018 you were part of the multidisciplinary team responsible for preparing and optimising Patient A for transfer, and you failed to:
   Amended under Rule 17(6)

   a. check functionality of the transport ventilator after the change of oxygen supply;
      Not proved

   b. respond appropriately to the alarms that were generated by the transport ventilator;
      Not proved

   c. identify the markers of the absence of ventilatory support before the point of secondary cardiac arrest, namely:

      i. Patient A's oxygen saturation falling;
         Not proved

      ii. Patient A further decompensating from a cardiovascular perspective to the point of irreversible cardiac arrest;
         Not proved

   d. in the alternative, record your actions or omissions, as outlined at paragraphs 1.~~b~~a to 1.~~d~~c.

Amended under Rule 17(6)
Not proved

2. On 18 August 2020, you were responsible for the care of Patient B and you:

a. failed to obtain an adequate history and/or undertake an adequate pre-operative assessment, including:

i. any American Society of Anesthesiologists background health classification;
Not proved

ii. any classification as to urgency under National Confidential Enquiry into Perioperative Death;
Not proved

iii. the weight and height of Patient B;
Not proved

iv. results of pre-operative investigations;
Not proved

v. the length of time since food or fluids had been taken;
Not proved

vi. whether Patient B had any symptoms of, or had been exposed to individuals with COVID-19;
Not proved

vii. exploring Patient B's previous tracheostomy;
Not proved

viii. whether there was any inspiratory stridor;
Not proved

b. failed to communicate your opinion that Patient B had undergone a previous tracheostomy to other healthcare professionals;
Not proved

c. inappropriately requested Operating Department Practitioner C attempt introduction of the endotracheal tube;
Admitted and found proved

d. completed an oesophageal intubation instead of intubating the trachea;
Determined and found proved

e. inappropriately diagnosed Patient B's complications as anaphylaxis;
Determined and found proved

f. failed to appropriately respond to your perceived diagnosis of anaphylaxis, including to request:

i. intravenous fluids;
Not proved

ii. hydrocortisone;
Not proved

iii. antihistamine agents;
Not proved

g. failed to correctly diagnose oesophageal intubation;
Admitted and found proved

h. continued to discount the correct diagnosis of oesophageal intubation as serious complications occurred, including:

i. progressive hypoxia;
Determined and found proved

ii. cardiovascular dysfunction;
Determined and found proved

iii. cardiac arrest;
Determined and found proved

i. failed to consider the alleged previous tracheostomy as a factor in Patient B's complications;
Determined and found proved

j. in the alternative, failed to record your actions or omissions as outlined at paragraphs:
Amended under Rule 17(6)

i. 2.a;
Not proved

ii. 2.b;
Not proved

iii. 2.g;
Not proved

iv. 2.~~j~~i.
Amended under Rule 17(6)
Not proved

And that by reason of the matters set out above your fitness to practise is impaired because of your misconduct. To be determined

Determination on Impairment - 06/07/2023

101. The Tribunal now has to decide in accordance with Rule 17(2)(l) of the Rules whether, on the basis of the facts which it has found proved as set out before, Dr Zghaibe's fitness to practise is impaired by reason of misconduct.

The Evidence

102. The Tribunal has taken into account all the evidence received during the facts stage of the hearing, both oral and documentary. In addition, the Tribunal received the following evidence.

103. Dr Zghaibe gave oral evidence again at this stage of the hearing. Dr Zghaibe's evidence assisted the Tribunal in understanding his level of insight and reflection, and the remediative steps he has taken since the index event.

104. Dr Zghaibe told the Tribunal that he has been in the role of specialty doctor at the Trust since 2021. Before that he had been practising as a locum consultant, and he explained the difference between those roles.

105. Dr Zghaibe informed the Tribunal how the interim order of conditions on his registration had changed since they were first imposed in January 2022. Initially, he was required to be subject to close supervision, this was varied to basic supervision in July 2022. At a further review in February 2023, the interim order was revoked.

106. Dr Zghaibe explained the nature of his interactions with his clinical supervisor, Dr H, during their fortnightly meetings for the purpose of his interim order.

107. Dr Zghaibe took the Tribunal through the CPD he has completed over the last three years, and also the Practitioners Performance Assessment ('PPA') involving behavioural and clinical assessments that he had undertaken in 2022. He told the Tribunal he had found the clinical assessment robust and demanding, as well as being stressful. However, he had wanted to co-operate and give his help and support to the Trust as well as showing he was willing to do whatever was required.

108. Dr Zghaibe informed the Tribunal he had undertaken simulation training to embed the *'ABCDE'* approach when managing patients, and had undergone specific faculty assessment regarding management of anaphylaxis and difficult airways. He had also

undergone leadership training to improve his communication with colleagues and his leadership status.

109. Dr Zghaibe told the Tribunal that he now had a more calm and balanced approach when faced with an emergency and provided the Tribunal with some examples from his recent practice. He has also learned to take a step back and have an open and, with colleagues, collective view of situations. He now reflects on what he has done and makes reflection a part of his daily practice.

110. Dr Zghaibe informed the Tribunal that he had made a simple and basic error in the case of Patient B that had grave consequences, one which should not have occurred. He could not reconcile how this had happened. He focused on the incorrect diagnosis from the outset, and although he had not been aware of the *'no trace, wrong place'* campaign he knew that no trace was an indication of a possible oesophageal intubation but had been misled by his *"confirmation bias".*

111. Dr Zghaibe referred to his *"internal focus"* and how he needs to deal with it. He explained to the Tribunal that he now verbalises his thought processes and asked his colleagues for advice and/or help when needed, rather than talking to himself in his mind as he had done previously.

112. In addition, the Tribunal received evidence from the following witnesses who provided testimonials and gave oral evidence to the Tribunal on Dr Zghaibe's behalf:

- Dr F, Consultant Anaesthetist and Intensivist at the Trust, by video link;
- Dr G, Consultant in Anaesthetics and Intensive Care Medicine at the Trust, by video link;
- Dr H, Dr Zghaibe's Clinical Supervisor at the Trust from January 2022 to February 2023, by video link.

113. The Tribunal received 15 further verified testimonials in support of Dr Zghaibe, including from practitioners at specialty doctor and consultant level, as well as from nursing staff. The testimonials confirmed they were aware of the GMC investigation and the nature of the allegations against Dr Zghaibe.

114. The Tribunal also received further documentation including:

<u>Documents for Interim Orders Tribunal Hearings</u>

- Dr H's Clinical Supervisor Reports for Dr Zghaibe's IOT hearings, dated 9 June 2022, 3 December 2022 and 9 February 2023.

<u>Evidence of Learning</u>

- 20+ CPD certificates for a range of courses including (but not limited to) Human Factors Workshops, Airway Management courses, Advanced Life Support course, 'Unconscious Bias in Healthcare' course and courses specific to tracheostomies and laryngectomies. These courses date from October 2020 to March 2023;
- Further reading: 'Implementing human factors in anaesthesia: guidance for clinicians, departments and hospitals. Guidelines from the Difficult Airway Society and the Association of Anaesthetists';
- Further reading: 'Preventing unrecognised oesophageal intubation: a consensus guideline from the Project for Universal Management of Airways and international airway societies';
- Prevent Further Deaths ('PFD') response letter from the Royal College of Anaesthetists ('RCoA') to HM Coroner, dated 5 December 2022.

Evidence of Remediation

- Letter from Mr I, PPA adviser, to Dr C, confirming completion of the PPA remediation Action Plan, dated 4 January 2023;
- Letter from Dr H to Dr Zghaibe's legal team, confirming completion of the PPA remediation Action Plan, dated 16 January 2023;
- Behavioural Assessment Report, dated 4 July 2022;
- Clinical Performance Assessment Report, dated 12 July 2022;
- Coaching Summary Reports, dated 20 January 2023 and 4 July 2023;
- Completed Action Plan showing all actions completed as of 29 December 2022.

Submissions

On behalf of the GMC

115. On behalf of the GMC, Mr Rose submitted that the failings of Dr Zghaibe in the case of Patient B were sufficiently serious as to warrant a finding of misconduct and impairment. He submitted all three limbs of the statutory overarching objective were engaged in this case.

116. In relation to misconduct, Mr Rose invited the Tribunal to consider the relevant case law as set out in *Remedy UK Ltd, R (on the application of) v General Medical Council* [2010] EWHC 1245 (Admin), and submitted that what happened with Patient B easily met the test of gross negligence.

117. Turning to impairment, Mr Rose referred the Tribunal to the case law as set out in the cases of *CHRE v NMC & Grant* (2011) EWHC 927 and *Cohen v General Medical Council* [2008] EWHC 581 (Admin).

118. Mr Rose reminded the Tribunal of Dr D's first expert report and the reasons Dr D set out to explain why, and how, Dr Zghaibe's failures relating to Patient B were so serious. Mr Rose submitted that securing the airway and the patient's breathing is a fundamental part of the anaesthetist's role, and any anaesthetist should be aware that oesophageal intubation

can happen, notwithstanding what the anaesthetist believes they have seen whilst carrying out the intubation. It therefore followed that the capnography, *"the gold standard",* in Dr D's words, was the minimum standard for monitoring correct placement of the endotracheal tube.

119. Mr Rose submitted that oesophageal intubation in itself was not a marker of sub-optimal practice but the failure to identify it was. He submitted that this was dangerous and led to Dr D's view that there was a serious shortfall in Dr Zghaibe's competence.

120. In relation to Dr Zghaibe's permitting the ODP to intubate Patient B, Mr Rose submitted that the Tribunal should view this in the context of the patient's complications, and that Dr Zghaibe accepted his decision was inappropriate in light of those complications. Mr Rose reminded the Tribunal of Dr D's opinion that delegation of responsibilities to the ODP constituted a standard of care delivery falling seriously below that expected.

121. Mr Rose then addressed Dr Zghaibe's failure to consider the alleged previous tracheotomy as a factor in Patient B's complications. Mr Rose submitted that, in Dr D's opinion, the combination of shortfalls including the failure to consider the previous tracheostomy that Dr Zghaibe believed Patient B had had, would constitute care that fell seriously below the expected standard.

122. Mr Rose drew the Tribunal's attention to the joint expert report of Dr D and Dr E and the part that addressed the allegation of the inappropriate diagnosis of anaphylaxis. Mr Rose submitted that while a competent practitioner would consider a range of diagnostic possibilities, what was so wrong in this case was that Dr Zghaibe focused solely on one possible explanation and one that was not supported by what was going on or what was being observed, for example the capnography trace. He submitted there was agreement between both experts that the failure to correctly diagnose oesophageal intubation was a serious shortfall.

123. Mr Rose then addressed Dr Zghaibe's continued discounting of oesophageal intubation in the face of serious complications occurring and submitted that the Tribunal, when considering impairment, would need to have regard to the fact that Dr Zghaibe did not step back, review or question his own diagnosis in the time he had before Patient B died.

124. Mr Rose drew the Tribunal's attention to the coroner's finding that had Dr Zghaibe conducted the basic *'ABCDE'* checks, then it was likely that Patient B would have survived, and that the coroner had used words such as *"negligence"* .

125. Mr Rose submitted that the Tribunal may conclude, on the basis of the expert evidence, that Dr Zghaibe's treatment of Patient B fell seriously below the required standard. Mr Rose also set out his reasons why the only finding the Tribunal could make was one of misconduct.

126. Mr Rose referred the Tribunal to the relevant paragraphs of Good Medical Practice (2013) ('GMP') which, he submitted, were engaged in this case, specifically paragraphs 7, 16 and 17.

127. Mr Rose submitted that when considering impairment, there may be a temptation to look to see what was deficient in Dr Zghaibe's knowledge base and practice, and then see how he had addressed those deficiencies. He submitted that undoubtedly, Dr Zghaibe had done a lot to remediate, and had reflected a lot. However, there would be a difficulty even in that approach because three years on, Dr Zghaibe was unable to explain how he made the basic mistakes he did. He submitted the Tribunal would need to go deeper and consider whether the errors revealed an underlying fault or problem in Dr Zghaibe's practice that needed to be remediated.

128. Mr Rose drew the Tribunal's attention to Dr Zghaibe's behavioural and clinical assessment reports, as well as Dr Zghaibe's oral evidence, that indicated that at times Dr Zghaibe could become overly focused on a diagnosis. Mr Rose submitted that this was not necessarily related to the complexity of a case but rather when Dr Zghaibe was under pressure.

129. Mr Rose submitted that there was little Dr Zghaibe had been able to say about why he failed in the way he did. He submitted that in his oral evidence, Dr Zghaibe told the Tribunal that he now seeks advice and help, and this was apparent from the evidence from witnesses who said this was not always necessary. Mr Rose invited the Tribunal to consider whether Dr Zghaibe was fit to practise unsupervised or if he still needed a level of supervision, such that his fitness to practise is currently impaired.

<u>On behalf of Dr Zghaibe</u>

130. On behalf of Dr Zghaibe, Mr Holl-Allen referred the Tribunal to case law that, he submitted, was relevant, including *Nandi v General Medical Council* [2004] EWHC 2317 (Admin) and *Calhaem v General Medical Council* [2007] EWHC 2606 (Admin).

131. Mr Holl-Allen submitted that paragraph 2(g) of the Allegation was, and remained, the central allegation and central failing in this case, a failure which Dr Zghaibe had at all times admitted.

132. Mr Holl-Allen submitted that of the six paragraphs found proved, paragraph 2(d) was a matter of fact, and that oesophageal intubation was not an uncommon occurrence; it was the failure to recognise it that was the failing in this case and the other failings flowed from that. All but paragraph 2(c) related to a point or a period in the sequence after the oesophageal intubation had occurred. As for paragraph 2(c) itself, that had been admitted by Dr Zghaibe.

133. Mr Holl-Allen referred to Mr Rose's submission regarding the wrongful delegation to the ODP and submitted that Dr E, in his expert report, had stated that Patient B's history was

what made this fall below the expected standard and that under usual circumstances it would not fall short of the standard. Dr E therefore considered this failing to be below, but not seriously below, the expected standard, and Mr Holl-Allen invited the Tribunal to accept Dr E's opinion.

134. Mr Holl-Allen submitted that when properly analysed, this was not a case of multiple serious failings but of one error that has been acknowledged to be serious, in failing to respond properly to the loss of the capnograph trace. This did not occur because Dr Zghaibe was being aggressive or dismissive. It was not in his nature to be either but the error occurred, in part, because of Dr Zghaibe's *"infectious certainty"*. Dr Zghaibe acknowledged his internal focus and confirmation bias provided further evidence to back up his diagnosis of anaphylaxis.

135. Mr Holl-Allen invited the Tribunal to ask itself if this error was sufficient to cross the boundary of misconduct. Mr Holl-Allen acknowledged this was a serious error with catastrophic consequences. It is a feature of anaesthetic practice that the anaesthetist is responsible for the health and life of their patient. There was a failure to follow the clear principle that in the absence of a capnograph trace, oesophageal intubation must be assumed until this diagnosis is discounted. However, if errors like this were easily avoidable, why, he asked, did oesophageal intubation continue to be a problem. In that regard, Mr Holl-Allen invited the Tribunal to have regard to recent guidelines on intubation and submitted that they note that oesophageal intubation still occurs at all levels of experience, despite attention being drawn to the problem and instructions as to how it should be dealt with. Mr Holl-Allen posited if this was a recognised error, was it appropriate to regard it as deplorable such that it crossed the threshold of misconduct?

136. Mr Holl-Allen cautioned the Tribunal in regard to the parts of Dr D's evidence relied upon by Mr Rose in his submissions, as many of Dr D's views had not been accepted by the Tribunal at the fact-finding stage of these proceedings.

137. Mr Holl-Allen drew the Tribunal's attention to the lapse of time since the case of Patient B, and that there had been no evidence of any significant problem with Dr Zghaibe's practice since that time. Dr Zghaibe had recognised and accepted from the outset the fundamental error he had made in his management of Patient B, and his responsibility for the outcome. It will have been apparent to the Tribunal that Dr Zghaibe had been profoundly affected by the incident and continued to be so, on a personal and professional level, because a life was lost under his care.

138. Mr Holl-Allen submitted that in the period since Patient B's death, Dr Zghaibe had been involved in a continuous process of remediation and self-assessment, and subjected to various investigations into the events of 18 August 2020. Dr Zghaibe had participated in an internal investigation at the Trust in 2020. In July 2021 he participated in an inquest in which he was commended by the coroner for his candour and honesty. Mr Holl-Allen reminded the Tribunal that the coroner's view had been specifically accepted by this Tribunal in its stage one determination. Dr Zghaibe had been subject to restrictions placed on his practice both

locally and by an IOT, and has engaged fully in behavioural and clinical assessment by the PPA Service of NHS Resolution.

139. Mr Holl-Allen took the Tribunal to the conclusions of the behavioural assessment in which the assessor, Dr J, concluded that Dr Zghaibe was cooperative and *"a well-liked and well-respected colleague"*. Dr J also wrote that, *"At the time of the critical incident, and as he himself has recognised, he became focused on a particular diagnosis to the extent that he lost situational awareness and perhaps, did not hear the reported challenges offered by two colleagues".*

140. Dr J found Dr Zghaibe:

> *"was unreserved in accepting his responsibility for the tragedy. He demonstrated insight into how his situational awareness had become compromised. He has been deeply affected on a* [XXX] *and emotional level and he is extremely remorseful. He is determined to learn from it, address systemic issues which may have contributed to the incident and to share his learning. He gave several examples of challenges to his colleagues, subsequent to the incident and the coroner's report, which demonstrated learning from his experience. He demonstrated the ability to be reflective and self-critical and a desire to learn as much as he can about human factors, his own behaviour, and the behaviour of others. He has also accepted the help and support offered by the Trust and has benefitted from mindfulness practice,* [XXX]*, and various educational opportunities to enhance his communication and leadership style."*

141. In relation to issues raised by the GMC regarding Dr Zghaibe's inability to explain how he came to make the error in diagnosis, Mr Holl-Allen submitted it was important to look at the totality of Dr Zghaibe's evidence. He acknowledged that Dr Zghaibe had been frank in acknowledging the difficulty in explaining his understanding of how he made the error, but it was not correct that Dr Zghaibe could provide no explanation for it. He submitted that Dr Zghaibe recognised the role the *'Grade 1'* view of the airway had in leading to his overconfidence that the trachea had been intubated. He had also explained how, having set out on the course of considering anaphylaxis, he was subject to confirmation bias in that he wrongly interpreted his observations to reinforce his erroneous diagnosis. Mr Holl-Allen submitted there clearly had been insight into why the error was made.

142. Mr Holl-Allen submitted it would be wrong to attach too much weight to some of the criticisms set out in the clinical assessment report, specifically those relating to Patient OB2. These criticisms related to Dr Zghaibe's assessment of the patient, and not his management of the situation. Aspects of the section of the report in which a judgment was made of *"poor quality"*, emphasised that the deficiencies had no impact on the patient's outcome. He submitted that Dr Zghaibe's clinical management was found to be satisfactory both in relation to the decision to transfer the patient and to administer medication, as well as his management of the insertion of a central line in what was acknowledged by the assessors to be a complex situation.

143. Mr Holl-Allen then addressed the GMC's main point that Dr Zghaibe was vulnerable in situations of particular stress and submitted that, apart from the case of Patient B, there was no evidence that his management or treatment of any patient has put that patient at risk of harm, and therefore the proposed basis for a finding that Dr Zghaibe's fitness to practise is impaired currently was not made out.

144. Returning to the sequence of events over the last few years in relation to remediation, Mr Holl-Allen submitted that Dr Zghaibe had worked diligently under close and basic supervision imposed by an IOT and progressed to revocation of the interim order of conditions. Dr Zghaibe had worked commendably quickly and thoroughly to address an action plan with the issues identified, and was able to complete this in a few months, with the Action Plan being signed off by the PPA Service. Dr Zghaibe had progressed to the point where he is now practising under the same degree of supervision as any other experienced speciality doctor.

145. Mr Holl-Allen reminded the Tribunal of the assessments carried out by Dr H and other consultants at the Trust, as to whether Dr Zghaibe was capable of performing at the standard required of a specialty doctor. Dr H confirmed that the vast majority of those assessments showed he was. Mr Holl-Allen submitted that it was important to bear in mind that this was not a case of alleged deficient performance where the whole of Dr Zghaibe's practice was being considered by the Tribunal but was one of misconduct. The question for the Tribunal was whether Dr Zghaibe's fitness to practise is currently impaired by reason of any misconduct the Tribunal has found proved.

146. Mr Holl-Allen submitted there was good evidence for the Tribunal to conclude Dr Zghaibe's fitness to practise is not currently impaired. It was not conceivable how he could have more promptly displayed insight and accepted responsibility for his errors. Dr Zghaibe had been consistent throughout with his candour in addressing his own role in Patient B's death and had approached rehabilitation and remediation with the utmost diligence. The remediation had not addressed only the clinical aspects, but also the human aspects of Patient B 's case. He had applied guidance on minimising risks and his current practice included video laryngoscopy, recognition and verbalisation of the state of the capnography trace and ventilation of his patients. It had been an important part of Dr Zghaibe's remediation that he had undertaken the Advanced Life Support and European Paediatric Advanced Life Support courses and was progressing to become an instructor.

147. In relation to the statutory overarching objective, Mr Holl-Allen submitted that there was no significant evidence that the public is at risk from Dr Zghaibe, and no evidence that Dr Zghaibe has practised other than safely in the last three years. Mr Holl-Allen submitted that oesophageal intubation is not uncommon. Given this, public protection was not a ground for a finding of impairment. The GMC had submitted that Dr Zghaibe's remediation was not complete but it was difficult to see how he could have done more over the last three years to address the issue. In relation to the other limbs of the overarching objective, Mr Holl-Allen submitted there was good reason to conclude a reasonably informed member of the public would not be concerned if there was no finding of impairment by the Tribunal because of the

approach to remediation which Dr Zghaibe had adopted from the very outset which indicated he had been profoundly impacted by the case and affected by it and was now a safe practitioner.

The Relevant Legal Principles

148. Throughout its deliberations, the Tribunal must take account of the statutory overarching objective of protecting the public, which includes protecting the health, safety, and wellbeing of the public, maintaining public confidence in the profession, and promoting and maintaining proper professional standards and conduct for the members of the profession.

149. The Tribunal reminded itself that at this stage of proceedings, there is no burden or standard of proof and the decision of impairment is a matter for the Tribunal's judgement alone.

150. In approaching the decision, the Tribunal was mindful of the two stage process to be adopted: first whether the facts as found proved amounted to misconduct, and then whether the finding of that misconduct which was serious, could lead to a finding of impairment.

151. The Tribunal must determine whether Dr Zghaibe's fitness to practise is impaired today, taking into account Dr Zghaibe's 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

Misconduct

152. In determining whether Dr Zghaibe's fitness to practise is impaired by reason of misconduct, the Tribunal first considered whether the facts found proved amount to misconduct.

Paragraph 2(c)

153. The Tribunal took into account Dr D's evidence that requesting the ODP attempt introduction of the endotracheal tube was inappropriate. Dr Zghaibe accepted that with hindsight it was inappropriate to have sought to provide a learning opportunity for the ODP on Patient B, and accordingly made an admission to this sub-paragraph of the Allegation at the outset of these proceedings.

154. The Tribunal had regard to Dr E's evidence in which he stated that under normal circumstances, making the request of the ODP would have been acceptable. However, given the issues around the presentation of Patient B, Dr Zghaibe's request was inappropriate. Patient B was not an appropriate patient for the ODP to have attempted introduction of the endotracheal tube. Dr E opined that Dr Zghaibe's request therefore fell below, but not seriously below, the expected standard of a reasonably competent practitioner.

155. The Tribunal accepted Dr E's opinion and concluded that, although misconduct, Dr Zghaibe's actions did not cross the threshold into misconduct that was serious.

Paragraph 2(d)

156. The Tribunal took into consideration that this was a factual allegation that Dr Zghaibe had completed an oesophageal intubation instead of intubating the trachea. It was not alleged that it was a failure by Dr Zghaibe to have done this and neither expert was critical of Dr Zghaibe for having done so, indeed it is a relatively common occurrence. Both were however critical of Dr Zghaibe for his subsequent failure to appreciate he had in fact intubated the oesophagus.

157. Accordingly, the Tribunal concluded that there was no misconduct in relation to its finding in respect of paragraph 2(d).

Paragraph 2(e)

158. The Tribunal concluded that it was inappropriate for Dr Zghaibe to have diagnosed Patient B's complications as anaphylaxis, given the absence of any capnograph trace. Dr Zghaibe was aware that an absent trace would most likely be due to an oesophageal intubation.

159. Both experts agreed that the diagnosis was incorrect but disagreed on the significance of this error. Dr E's view was that it was not inappropriate given Dr Zghaibe's mistaken belief that there was no problem with the intubation of Patient B. The Tribunal disagreed with Dr E on this. Dr D considered it to be a significant error, due to the absence of any trace. Dr Zghaibe should have taken a step back and reassessed the situation to ensure that the intubation was correctly sited. Based on the presentation of the patient, it should have been clear to Dr Zghaibe that anaphylaxis was an inappropriate diagnosis and it was clinically inappropriate for Dr Zghaibe to have pursued this line of thinking and treatment. He should, with the absent trace, have gone back to *'ABCDE'*. Had he done so, he would have identified the oesophageal intubation.

160. The Tribunal therefore determined that Dr Zghaibe's diagnosis of Patient B's complications as anaphylaxis fell significantly below the standard one would expect of a doctor and concluded that this was misconduct that was serious.

Paragraph 2(g)

161. The Tribunal had regard to the fact that both experts agreed Dr Zghaibe's failure to correctly diagnose oesophageal intubation was a serious failure. The Tribunal considered that this should have been the first check made by Dr Zghaibe to assess Patient B's airways, given there was no trace on the capnograph. The Tribunal noted that the Registrar raised with Dr Zghaibe the possibility of an oesophageal intubation which Dr Zghaibe rejected.

162. The Tribunal took into account Dr D's evidence that the capnograph trace was the *"gold standard"* as well as Dr E's evidence that the shortfall in care was serious and that Dr Zghaibe should have looked at the capnograph trace and realised the first thing he needed to exclude was oesophageal intubation.

163. The Tribunal was of the view that it should have been obvious to Dr Zghaibe, who knew that an absent capnograph trace was an indicator of likely oesophageal intubation, that this was the most likely cause for the reading. This should have led him to assess Patient B's airway, and the fact he had had a *'Grade 1'* view did not exclude the occurrence of an oesophageal intubation. The Tribunal considered Dr Zghaibe's actions in this regard represented a significant departure from GMP paragraphs 7 and 16 which state:

> ***7*** *You must be competent in all aspects of your work, including management, research and teaching*
>
> ***16*** *In providing clinical care you must:*
>
> ***a.*** *provide effective treatments based on the best available evidence*
> ***b.*** *…*
> ***c.*** *consult colleagues where appropriate*

164. The Tribunal therefore concluded there had been a serious failure by Dr Zghaibe to identify and correct a basic failure, which as a consequence led to the loss of a patient's life. The Tribunal concluded that Dr Zghaibe's failure to identify the oesophageal intubation in Patient B amounted to serious misconduct.

Paragraph 2(h)(i)to(iii)

165. The Tribunal had regard to the evidence of both expert witnesses. Dr D and Dr E were in agreement that Dr Zghaibe's sustained diagnosis of anaphylaxis was seriously below the standards expected of him, with Dr E describing it as a *"serious shortfall in his care"*.

166. The Tribunal considered Dr Zghaibe's persistence with an incorrect diagnosis, despite the serious complications that were occurring with Patient B and which should have led to him reassessing Patient B's airway, to be a significant failure.
The Tribunal was therefore satisfied that its finding in respect of paragraph 2(h)(i) to (iii) of the Allegation amounted to misconduct that was serious.

Paragraph 2(i)

167. The Tribunal took into account the expert evidence that it would be rare for a previous tracheostomy to lead to a complication during intubation. However, having believed Patient B to have previously had a tracheostomy, it is something Dr Zghaibe should have had

regard to in order to exclude it, especially given his belief that he had not carried out an oesophageal intubation.

168. The Tribunal concluded that while Dr Zghaibe should have considered a previous tracheotomy, given it was very unlikely to have been the cause of Patient B's deterioration, his failure to do so, while misconduct, did not cross the threshold into misconduct that was serious.

Overall

169. The Tribunal concluded that Dr Zghaibe's conduct fell so far short of the standards of conduct reasonably to be expected of a doctor as to amount to misconduct that is serious in relation to paragraphs 2(e), 2(g) and 2(h) of the Allegation.

Impairment

170. The Tribunal having found facts proved which amounted to serious misconduct, went on to consider whether, as a result of that serious misconduct, Dr Zghaibe's fitness to practise is currently impaired.

171. In determining impairment, the Tribunal first considered whether the misconduct could be remediated. It noted the misconduct related to the clinical care of a single patient and was of the view that the misconduct could be remediated. The Tribunal then looked for evidence of insight, remediation and the likelihood of repetition and balanced those against the three limbs of the statutory overarching objective.

172. The Tribunal had regard to whether Dr Zghaibe had insight into his misconduct. It considered Mr Rose's submission that Dr Zghaibe is still unable to fully articulate why he behaved in the way he did when managing the treatment of Patient B, and therefore lacks full insight. It noted however, that as set out by Mr Holl-Allen in his submission, Dr Zghaibe has sought to provide an explanation as to why he became fixated on an incorrect diagnosis and made what should have been an obvious error in not diagnosing oesophageal intubation.

173. The Tribunal took into account that Dr Zghaibe had recognised his failures from the start and has openly admitted these in respect of his treatment of Patient B. Although he had not admitted all the allegations the Tribunal found proved, he had done so on the basis that his failings in respect of his persistence with a diagnosis of anaphylaxis arose out of his mistaken belief that there had not been an oesophageal intubation. He admitted from the outset that it had been a failure not to have correctly diagnosed the oesophageal intubation.

174. The Tribunal noted Dr C's letter to the GMC dated 20 April 2021, attesting to the profound effect of the events on Dr Zghaibe, and that he showed insight into his failings. Dr C also confirmed to the Tribunal that Dr Zghaibe had developed good insight and had many reflective conversations with colleagues about what had occurred.

175. The Tribunal considered that the steps undertaken by Dr Zghaibe to remediate was further evidence of his insight. Dr Zghaibe has taken a number of relevant and extensive courses since 2021, covering both the technical issue of airway management and life support and the human factors around decision making which were associated with his misconduct.

176. The Tribunal had regard to the evidence from Dr Zghaibe that he had altered his process of intubating by now using video laryngoscopies and he also verbalises what he is doing. He engages with other colleagues and his thought process is also verbalised rather than internalised. The Tribunal considered this to demonstrate insight into a past failing and that Dr Zghaibe had taken practical steps to overcome this failing.

177. The Tribunal considered that Dr Zghaibe had reflected over a significant period since the death of Patient B. He is clearly genuinely remorseful over what happened and the part that his failings played in the death of Patient B. Although he offered to meet with Patient B's family, this was not taken up. He has fully co-operated with the Trust investigation and the Inquest. As previously noted, his openness in his evidence to the Inquest was commented on positively by the coroner. Dr G, in his testimonial, wrote:

> *"The tragic incident that Dr Zghaibe was involved in has affected him greatly. He demonstrates remorse daily and has reflected at great length. Dr Zghaibe has undertaken many hours/days of learning and re-learning to further improve his skills and make sure he has learnt the lessons from this incident and to make sure it never recurs."*

178. The Tribunal was of the view that Dr Zghaibe has a clear understanding of what went wrong. This is supported by the evidence of Dr C, Dr J, and Dr K (a Consultant Anaesthetist and Intensive Care Physician at the Trust), as well as others who work with Dr Zghaibe on a daily basis and gave evidence as to his insight into what went wrong. The Tribunal concluded that Dr Zghaibe has developed full insight into his misconduct.

179. Turning to the matter of remediation, the Tribunal concluded that Dr Zghaibe started the process of remediating his misconduct shortly after the index incident. The Tribunal had regard to the extensive CPD Dr Zghaibe has undertaken, including Advanced Life Support, and the Human Factors workshop which lasted for several hours over multiple days. The Tribunal was satisfied that the fact that Dr Zghaibe had completed a number of Human Factors courses demonstrated him recognising that his approach to the difficult situation he found himself in with Patient B was a factor that he needed to address. Dr Zghaibe has watched the *'no trace, wrong place'* information video multiple times to fully reinforce the importance of checking the placement of the endotracheal tube.

180. The courses attended by Dr Zghaibe have all been appropriate to his failings and what occurred with Patient B, and have included 20 hours of airway management learning. Additionally, Dr Zghaibe had taken courses on communicating and leadership skills. The Tribunal considered these courses to all be relevant and appropriate, and completed over a

significant period of time. Importantly, the Tribunal noted that Dr Zghaibe has applied his learning to his practice.

181. The Tribunal had regard to Dr Zghaibe's PPA, carried out over three days, that looked at both personal and clinical aspects of his role as a doctor. The Tribunal noted the extensive number of observations, including nine live interactions and three simulated patient encounters. There were multiple pages of satisfactory clinical assessments, with a few being marked as *'poor'.* The Tribunal took into consideration that some of the critical feedback related to Dr Zghaibe being slow in a pre-operative assessment, and being too thorough.

182. The Tribunal took into account Dr Zghaibe's fortnightly meetings with Dr H, who confirmed that Dr Zghaibe complied with his Action Plan to address the matters identified in the PPA in a timely manner and that the Action Plan was signed off by the PPA Adviser as having remediated all the identified issues.

183. The Tribunal concluded that Dr Zghaibe has fully remediated. It agreed with the observation made by Mr Holl-Allen that it is difficult to see what more Dr Zghaibe could have done by way of remediation.

184. The Tribunal took Dr Zghaibe's level of insight and extent of remediation into account when assessing any risk of repetition of the misconduct in this case. The Tribunal had regard to the fact that the role of an anaesthetist is a pressurised one and on many occasions will be stressful for the anaesthetist as the patient's health and life is in their hands.

185. The Tribunal also took into account a recent situation as reported in the clinical assessment, relating to Patient OB2 who was deteriorating. Although it was noted that he had become fixated with midazolam, the Tribunal accepted Dr Zghaibe's explanation for this and that he had been commended by his colleagues for his treatment of the patient during a presentation. It also noted the clinical assessment occurred over a year ago, and Dr Zghaibe had completed the required Action Plan. The clinical assessment had accepted that he was competent to work as a speciality doctor in anaesthetics.

186. The Tribunal was encouraged by the positive comments and testimonials from his colleagues, and Dr Zghaibe's willingness to ask for assistance when required. The Tribunal heard from a number of consultants who had recently supervised Dr Zghaibe and considered him to be a safe doctor.

187. The Tribunal noted that there have been no further issues of concern about Dr Zghaibe over the past three years. It took into account that for the past five months there have been no conditions on his practice and he had been working without any restrictions. Dr Zghaibe works in an area of medicine where there will always be an element of pressure, but the Tribunal is satisfied that Dr Zghaibe through his insight and remediation will be able to sufficiently manage that pressure.

188. Taking into account Dr Zghaibe's full insight and remediation, the Tribunal concluded that Dr Zghaibe currently poses a low risk of repeating the misconduct in his clinical practice. It was therefore satisfied it was unnecessary to make a finding of impairment in order to protect the public.

189. Having concluded that there was no real risk to patient safety in Dr Zghaibe returning to unrestricted practice, the Tribunal then considered whether it would need to make a finding of impairment in order to satisfy the second and third limbs of the overarching objective.

190. The Tribunal considered Dr Zghaibe's full insight and remediation, which had started shortly after the misconduct occurred. It also noted that oesophageal intubation was not an uncommon occurrence. Despite a campaign and other various attempts to draw attention to the issue of unrecognised oesophageal intubation, it was still occurring nationally and worldwide.

191. The Tribunal acknowledged that there had been a catastrophic and tragic consequence to Dr Zghaibe's misconduct, with the loss of Patient B's life. The Tribunal took into account that Dr Zghaibe had made all efforts to understand what had gone wrong. He had been remorseful and done as much as he could to address and remediate the issues. Dr Zghaibe had put measures in place to ensure he would not make the same mistakes again. The Tribunal also took into consideration that Dr Zghaibe has been through an inquest and the regulatory disciplinary process, fully co-operating.

192. The Tribunal was of the view that a fully informed member of the public would not be shocked if a finding of current impairment was not made, and public confidence in the profession would not be undermined.

193. The Tribunal had made a public finding of serious misconduct. It concluded that to go on to make a finding of impairment was not necessary to maintain public confidence in the profession or to promote and maintain proper professional standards.

194. The Tribunal has therefore determined that Dr Zghaibe's fitness to practise is not currently impaired.

Determination on Warning - 06/07/2023

195. As the Tribunal determined that Dr Zghaibe's fitness to practise was not impaired it considered whether in accordance with s35D(3) of the 1983 Act, a warning was required.

Submissions

196. On behalf of the GMC, Mr Rose set out the purpose of imposing a warning. He submitted that there had been significant departures from GMP and that the Tribunal had found three of the proven allegations amounted to serious misconduct.

197. Mr Rose submitted that on the basis of the Tribunal's findings it was proper to issue a warning, particularly given its explicit statement that there was a significant departure from GMP by Dr Zghaibe in respect of paragraph 2(g) of the Allegation.

198. Mr Rose referred the Tribunal to the paragraphs of the Guidance on warnings (March 2021) ('the Guidance') that were engaged in this case, and submitted the Tribunal should have regard to the public interest when considering whether to issue a warning to Dr Zghaibe.

199. Mr Rose invited the Tribunal to consider the factors set out in paragraph 20 of the Guidance. He submitted Mr Holl-Allen would no doubt draw paragraph 32 to the attention of the Tribunal, which was in favour of Dr Zghaibe. He submitted that, even taking into account the factors in paragraph 32, a warning was appropriate.

200. On behalf of Dr Zghaibe, Mr Holl-Allen submitted that the Tribunal should read paragraphs 16 and 32 of the Guidance in conjunction with each other. He submitted that the individual sub-paragraphs of paragraph 32 should count strongly in Dr Zghaibe's favour. Mr Holl-Allen reminded the Tribunal of its findings at the impairment stage related to these sub-paragraphs.

201. Mr Holl-Allen pointed out to the Tribunal that only one finding of misconduct had been designated a significant departure from GMP.

202. Mr Holl-Allen submitted in conclusion that Dr Zghaibe was not a practitioner who required the formalisation of a warning in order that he would not transgress in the same way again. He submitted that in circumstances where the Tribunal had already formally and publicly recorded the seriousness of Dr Zghaibe's failures through its findings of serious misconduct, a warning was not necessary.

The Tribunal's Determination on Warning

203. The Tribunal had regard to the Guidance and reminded itself of the overarching objective in making its decision. The Tribunal noted that a warning would be appropriate if there was evidence to suggest that Dr Zghaibe's behaviour or performance had fallen below the standard expected to a degree warranting a formal response.

204. The Tribunal considered that although no finding of current impairment had been made it had found three incidents of serious misconduct in this case which require a formal response. As already noted by the Tribunal there had been a significant departure from the principles set out in GMP by Dr Zghaibe in his management of Patient B.

205. The Tribunal took into consideration, in particular, paragraphs 16, 20, 26 and 32 of the Guidance. These state:

> *16 A warning will be appropriate if there is evidence to suggest that the practitioner's behaviour or performance has fallen below the standard expected to a degree*

warranting a formal response by the GMC or by a MPTS tribunal. A warning will therefore be appropriate in the following circumstances:

- *there has been a significant departure from Good medical practice, or*
- *…*

20 The decision makers should take account of the following factors to determine whether it is appropriate to issue a warning.

a There has been a clear and specific breach of Good medical practice or our supplementary guidance.
b The particular conduct, behaviour or performance approaches, but falls short of, the threshold for the realistic prospect test or in a case before a tribunal, that the doctor's fitness to practise has not been found to be impaired.
c A warning will be appropriate when the concerns are sufficiently serious that, if there were a repetition, they would likely result in a finding of impaired fitness to practise. Warnings may be an appropriate response to any type of allegation (subject to the comments in paragraph 7 regarding cases solely relating to a doctor's health); the decision makers will need to consider the degree to which the conduct, behaviour or performance could affect patient care, public confidence in the profession or the reputation of the profession. If the decision makers consider that a warning is appropriate, the warning should make clear the potential impact of the conduct, behaviour or performance in question, accordingly.
d There is a need to record formally the particular concerns (because additional action may be required in the event of any repetition).

26 In deciding whether to issue a warning the decision maker should apply the principle of proportionality, weighing the interests of the public with those of the practitioner. It is important to bear in mind, of course, that warnings do not restrict the practitioner's practice and should only be considered once the decision maker is satisfied that the doctor's fitness to practise is not impaired.

32 If the decision makers are satisfied that the doctor's fitness to practise is not impaired or that the realistic prospect test is not met, they can take account of a range of factors to determine whether a warning is appropriate. These might include:

a the level of insight into the failings
b a genuine expression of regret/apology
c previous good history
d whether the incident was isolated or whether there has been any repetition
e any indicators as to the likelihood of the concerns being repeated
f any rehabilitative/corrective steps taken
g relevant and appropriate references and testimonials.

206. The Tribunal also had regard to paragraphs 7 and 16 of GMP.

207. The Tribunal took into account that the factors set out in paragraph 32 of the Guidance all counted in Dr Zghaibe's favour. It balanced these with what it considered to be significant departures from GMP by Dr Zghaibe.

208. The Tribunal bore in mind that warnings can emphasis the message to the public and the profession that misconduct is not acceptable, and determined that in this case a warning would mark the seriousness of the misconduct.

209. The Tribunal was of the view that notwithstanding Dr Zghaibe's remediation and insight, his misconduct in failing to recognise the basic error of his management of Patient B leading to their death was so serious that issuing a warning was the only proportionate response.

210. The Tribunal considered that its duty to uphold and maintain public confidence in the profession meant that it was appropriate to issue a warning in this case. It also considered that a warning was necessary to send a message to the profession about maintaining proper professional standards.

211. The Tribunal therefore determined to issue the following warning in accordance with Section 35D(3) of the Medical Act 1983 and Rule 17(2)(n) of the Rules:

> 'On 18 August 2020, Dr Zghaibe was responsible for the care of a patient and completed an oesophageal intubation instead of intubating the trachea. Dr Zghaibe incorrectly diagnosed the oesophageal intubation as anaphylaxis. Dr Zghaibe continued to discount the correct diagnosis even as serious complications occurred. As a result of Dr Zghaibe's failures, the patient died.
>
> Dr Zghaibe should have realised his fundamental error of oesophageal intubation from the loss of the capnograph trace. His failure was significantly below the standard expected of a reasonably competent consultant anaesthetist.
>
> This conduct does not meet the standards required of a doctor. It risks bringing the profession into disrepute and it must not be repeated. The required standards are set out in paragraphs 7 and 16 of Good medical practice:
>
> ***7*** *You must be competent in all aspects of your work…*
>
> ***16*** *In providing clinical care you must:*
>
> *a. provide effective treatments based on the best available evidence*
> *b. …*
> *c. consult colleagues where appropriate*
>
> Whilst Dr Zghaibe's misconduct in itself is not so serious as to require any restriction on his registration, it is necessary in order to declare and uphold proper standards of

conduct and behaviour and to maintain public confidence in the profession to issue this formal warning.

This Warning will be published on the List of Registered Medical Practitioners (LRMP) in line with our publication and disclosure policy, which can be found at www.gmc-uk.org/disclosurepolicy '

212. There is no interim order to revoke.

213. That concludes this case.

ANNEX A – 19/01/2023

APPLICATION FOR ADJOURNMENT

214. As this determination concerns XXX a witness, it will be handed down in private. A redacted version will be published at the close of the hearing with those matters relating to XXX removed.

215. At the outset of the hearing Mr Rose, Counsel, on behalf of the GMC, raised as a preliminary matter under Rule 17(2)(a), the inability of the GMC to commence its case due to the XXX witness XXX.

216. Mr Rose applied to adjourn the hearing and set out three possible scenarios which he invited the Tribunal to consider.

217. The GMC's preferred option was for the Tribunal not to formally commence the hearing immediately, but to instead adjourn for a period of one week XXX. Mr Rose informed the Tribunal that there was a risk, albeit small, that XXX may be unable XXX to give evidence during the current listing of this case. He therefore invited the Tribunal to consider not formally commencing the hearing until it could be confirmed that XXX give evidence. Mr Rose submitted that, with the Tribunal's agreement, XXX could give XXX evidence via video link rather than in person, which should assist XXX.

218. The other two options were, Mr Rose submitted, less appealing; the hearing could commence but would have to adjourn after he had opened the case. In doing so there was a risk that XXX and the case could not proceed further, any future listing would in those circumstances be constrained by the Tribunal members' availability. Finally, he submitted that the Tribunal could refuse to adjourn the hearing. If the Tribunal refused the application the GMC would be unable to proceed to make its case, given the importance of XXX evidence as it forms the basis of the Allegation.

219. Having been invited by the Tribunal to enquire of XXX whether XXX might XXX give XXX evidence in small sessions over a number of days, Mr Rose confirmed this was a possibility and he therefore invited the Tribunal to adjourn the case for a period of three days until Thursday 12 January 2023, with the intent for XXX to give evidence in two sessions of up to two hours, with breaks, on that day and the following. Mr Rose informed the Tribunal that should be sufficient time to conclude XXX evidence.

220. Mr Holl-Allen KC, on behalf of Dr Zghaibe, submitted that in the circumstances he agreed that the GMC's preferred option of adjourning without commencing the hearing was the appropriate course to take. He therefore did not oppose the adjournment and was

content for XXX to give XXX evidence via video-link, in two sessions of up to two hours each day.

The Tribunal's Decision

221. The Tribunal considered that it was appropriate to adjourn the hearing given XXX. It was satisfied that it was not in the public interest to proceed, given the importance of XXX evidence to the Allegation. It took into account that there was no objection raised on behalf of Dr Zghaibe to the GMC's adjournment application.

222. In all the circumstances, the Tribunal was satisfied that it was appropriate to adjourn the hearing for a short period of time. It was content with XXX assurance that a short adjournment should enable XXX to give XXX evidence via video-link over a number of short sessions each day.

223. The Tribunal accepted the submissions of both parties not to formally commence the hearing, until certain XXX was able to give evidence. It took into account that if it did, and XXX, any future listing of the case would be constrained by the Tribunal members' availability. This could result in a longer delay than if the case had not formally commenced and such a delay would neither be in Dr Zghaibe's nor the public interest.

224. Accordingly, the Tribunal concluded, under Rule 29 of the Rules, to grant Mr Rose's application to adjourn the hearing, until 9.30am on 12 January 2023.

ANNEX B – 27/01/2023

Application to adjourn hearing

225. On 25 January 2023, following the Tribunal handing down its Stage 1 determination on the facts, Mr Rose invited the Tribunal to adjourn the hearing under Rule 29(2) of the Rules which states:

> *"Where a hearing of which notice has been served on the practitioner in accordance with these Rules has commenced, the Committee or Tribunal considering the matter may, at any stage in their proceedings, whether of their own motion or upon the application of a party to the proceedings, adjourn the hearing until such time and date as they think fit."*

226. Mr Rose invited the Tribunal to consider adjourning the proceedings rather than starting the next stage of the case, as there was insufficient time remaining in which to conclude the Impairment stage. Both parties were in agreement that it was preferable that

the Tribunal did not start Stage 2 of the proceedings, if it could not be concluded in the remaining time available.

Submissions

227. Mr Rose submitted that it was a matter for the Tribunal whether it should proceed or adjourn at this stage. He submitted that the Tribunal had now reached a convenient point in the proceedings at which to adjourn. Given the remaining time and that there was further evidence from Dr Zghaibe, it was unlikely the Tribunal could reach a decision on whether or not Dr Zghaibe's fitness to practice was impaired in the remaining time available. That question was an important one for the Tribunal to resolve and it should not be put under time pressure.

228. Mr Rose reminded the Tribunal of the risks in the Tribunal starting deliberations and not concluding them, in particular that given the likely delay in being able to resume the hearing Dr Zghaibe may wish to provide further evidence to the Tribunal, by way of an update on insight or remedial steps he had taken. As such, he submitted, the Tribunal would not necessarily save time in starting now if it were to receive further evidence and submissions when the hearing resumed later in the year.

229. Mr Holl-Allen informed the Tribunal that there was a further bundle of evidence from Dr Zghaibe, running to some 300 pages, for the Tribunal to consider at the next stage of the hearing. There would also be three witnesses called on behalf of Dr Zghaibe to give evidence and all three could be made available to give their evidence in the time remaining. However, accepting it was ultimately a matter for the Tribunal, Mr Holl-Allen submitted that it would be disadvantageous to Dr Zghaibe if the Tribunal proceeded knowing it was unlikely Stage 2 would be completed.

230. Although there might not be a substantial amount of further evidence from Dr Zghaibe if the Tribunal adjourned, Mr Holl-Allen indicated that, given the likely passage of time before the Tribunal was able to reconvene, further up to date evidence might be provided by Dr Zghaibe. Mr Holl-Allen informed the Tribunal that Dr Zghaibe was subject to an Interim Order of Conditions and was subject to supervision. He confirmed that Dr Zghaibe was aware that it was unlikely the Tribunal would be in a position to resume the hearing until June 2023 at the earliest. However, given the potential disadvantage to him in proceeding at this time, Dr Zghaibe did not oppose the proposed adjournment.

231. Both Mr Rose and Mr Holl-Allen were in agreement that a further period of six days would be required in order for the Tribunal to have sufficient time to conclude the hearing.

The Tribunal's Determination

232. The Tribunal noted that it must balance the needs of Dr Zghaibe with the public interest in ensuring hearings are disposed with efficiently and fairly. It was mindful that any delay may cause unfairness to either or both parties.

233. Both Mr Rose and Mr Holl-Allen, having seen the additional evidence for Stage 2 of the proceedings were of the view that it was unlikely that the Tribunal could conclude Stage 2 in the remaining time available. They agreed that it would be unsatisfactory to commence the Impairment stage and for the Tribunal to have to adjourn before it could reach a decision. There would then follow a lengthy period before the Tribunal could resume to reach its determination. The Tribunal agreed, based on what it had heard from the parties, that it was unlikely that it could conclude Stage 2 of the hearing in the remaining time.

234. The Tribunal considered whether it was appropriate to start Stage 2 believing it highly improbable that it would complete it in the remaining time available. It noted the need to dispose of hearings in an efficient manner and that, by adjourning, potential sitting time would be lost. It took into account that it could possibly consider the Stage 2 bundle of evidence, hear from the witnesses and if there was sufficient time receive submissions from the parties. However, it was mindful of the substantial delay before the Tribunal would be able to reconvene the hearing and reach a decision. The Tribunal was of the view that it was important that it had up to date evidence fresh in its mind when reaching its decision on the question of impairment. The Tribunal accepted the submission made by Mr Holl-Allen that a substantial delay between hearing the evidence and reaching a decision would be disadvantageous to Dr Zghaibe. It noted that Mr Rose had not sought to persuade the Tribunal otherwise.

235. The Tribunal also accepted the point made by Mr Rose that the length of delay might understandably lead to Dr Zghaibe wishing to provide up to date evidence, something confirmed by Mr Holl-Allen, and as such the Tribunal would need to revisit the evidence and submissions when it resumed.

236. Taking all of the above into consideration the Tribunal concluded that, as had been submitted by both parties, it was appropriate to adjourn the hearing at this point rather than risk commencing and not completing Stage 2 of the hearing.

237. The Tribunal therefore adjourned the hearing until 09:30 on 3 July 2023. It directed that any further evidence to be relied upon by Dr Zghaibe at the Impairment stage must be disclosed to the GMC at least 14 days before the hearing recommences.