Record of Determinations –
Medical Practitioners Tribunal

PUBLIC RECORD

Dates: 08/04/2019 - 24/04/2019
Medical Practitioner’s name: Dr Christopher MAWSON
GMC reference number: 7080041
Primary medical qualification: MB ChB 2010 University of Leeds
Type of case
New - Misconduct
Outcome on impairment
Impaired

Summary of outcome
Suspension, 2 months.

Tribunal:

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<td>Legally Qualified Chair</td>
<td>Mr Damian Cooper</td>
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<tr>
<td>Lay Tribunal Member:</td>
<td>Mr Andrew Waite</td>
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<td>Medical Tribunal Member:</td>
<td>Dr Joanne Topping</td>
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<td>Ms D Montgomery</td>
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Attendance and Representation:

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<td>Medical Practitioner:</td>
<td>Present and represented</td>
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<td>Medical Practitioner’s Representative:</td>
<td>Mr Richard Partridge, Counsel, instructed by BLM Solicitors</td>
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<td>GMC Representative:</td>
<td>Ms Sarah Barlow, Counsel</td>
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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.
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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 - 17/04/2019

Background

1. Dr Mawson qualified in 2010 and commenced his Foundation Year (FY) 1 training at the Mid Yorkshire Hospitals Trust in August 2010. His FY2 training was undertaken at Leeds Teaching Hospitals Trust (LTHT) and in August 2013 Dr Mawson commenced Specialist Training (ST) in Obstetrics and Gynaecology with LTHT. He undertook the first part of his ST5 training at the Calderdale and Huddersfield NHS Foundation Trust (the Trust) between August 2016 and January 2017. At the time of the events Dr Mawson was practising as an ST5 Locum practitioner working at the Calderdale Royal Hospital.

2. The allegation that has led to Dr Mawson’s hearing can be summarised as concerns relating to the clinical care provided by Dr Mawson to Patients A and B and concerns relating to an alteration made by Dr Mawson to Patient A’s medical record. It is alleged that Dr Mawson’s action in altering the record was dishonest.

3. The initial concerns were raised with the General Medical Council (GMC) on 7 July 2017 by Dr C, Medical Director and Responsible Officer at the Trust.

The Outcome of an Application made during the Facts Stage

4. The Tribunal granted the GMC’s application, made pursuant to Rule 17(6) of the GMC (Fitness to Practise) Rules 2004 (the Rules), to amend paragraph 1 of the Allegation for the purposes of clarification as set out below. Except for sub-paragraph 1(c)(i) and 1(c)(iv) the application was unopposed by Mr Partridge, Counsel, on behalf of Dr Mawson. Mr Partridge did not believe that sub-paragraphs 1(c)(i) and 1(c)(iv) needed to be separately alleged. The Tribunal agreed with Mr Partridge and amended sub-paragraph 1(c)(i) as set out below and deleted sub-paragraph 1(c)(iv).

The Allegation and the Doctor’s Response

5. The Allegation made against Dr Mawson is as follows:

1. On 18 March 2017 you assessed Patient A (‘the Assessment’) and you:
a. failed to discuss with Patient A the level of intervention and resuscitation that Patient B should undergo at the time of birth;

b. a. inappropriately counselled Patient A that:
   i. Patient B was ‘not for intervention at birth due to gestation’; To be determined
   ii. there should be no input from paediatrics; To be determined

c. failed to discuss with the on call consultant or Senior Obstetrician whether and how to monitor Patient B’s heart rate during labour;

b. failed to discuss with the on call consultant or Senior Obstetrician:
   i. whether and how to monitor Patient B’s heart rate during labour; Admitted and found proved as amended
   ii. the option of administering steroid injections to improve Patient B’s lung maturity; Admitted and found proved as amended

d. c. failed to contact, or request that the midwifery team contact, a Paediatrician or Neonatologist to discuss with Patient A:
   i. the level of intervention (including options for possible resuscitation) that Patient B should undergo at the time of birth; Admitted and found proved as amended
   iii. the survival rates of very pre-term infants; Admitted and found proved as amended
   ii. the option of administering steroid injections to improve Patient B’s lung maturity;
   iii. possible short and long term consequences of Patient B’s prematurity; Admitted and found proved as amended
   iv. the options for possible resuscitation of Patient B;
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e.d. recorded that Patient B was ‘not for intervention at birth due to gestation’ which was inappropriate because:

i. it was possible that Patient B would survive
   1. labour; **To be determined**
   2. birth; **To be determined**

ii. you had not discussed Patient B’s care with:
   1. the consultant on call; **To be determined**
   2. a paediatrician or neonatologist; **To be determined**
   3. a neonatologist;

f.e. at 09:05 you altered your 05:15 record entry from ‘not for intervention at birth due to gestation’ (‘the original record’) to ‘not for resuscitation at birth if unwell due to gestation. Mr A aware of events and agree’ (‘the altered record’). **Admitted and found proved as amended**

2. You made the altered record, after having been informed that Patient B was born with signs of life and had showed signs of life following birth, which did not accurately reflect your instructions as contained in the original record. **To be determined**

3. Your actions as described at paragraph 1f.e were dishonest by reason of paragraph 2. **To be determined**

The Admitted Facts

6. At the outset of these proceedings, through his Counsel, Mr Partridge, Dr Mawson made admissions to some 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 sub-paragraphs of the Allegation as admitted and found proved.

The Facts to be Determined

7. In light of Dr Mawson’s response to the Allegation made against him, the Tribunal is required to determine whether Dr Mawson inappropriately counselled Patient A that Patient B was not for intervention at birth due to gestation and that
there should be no input from paediatrics. It is also required to determine whether Dr Mawson inappropriately recorded this in Patient A’s medical records.

8. The Tribunal is also required to determine whether Dr Mawson’s subsequent amendment of Patient A’s record, after he had been informed that Patient B had been born with signs of life and had shown signs of life following birth, was dishonest.

Factual Witness Evidence

9. The Tribunal received evidence on behalf of the GMC from the following witnesses from the Trust:

- Dr D, General Practitioner ST1 at the time of events, in person
- Ms E, Midwife, in person
- Ms F, Midwife, in person
- Ms G, Midwife, in person
- Ms H, Midwife, in person
- Ms I, Labour Ward Coordinator at the time of events, in person
- Dr J, Consultant in Gynaecology and Obstetrics, in person.

10. The Tribunal also received evidence on behalf of the GMC in the form of witness statements from the following witnesses who were not called to give oral evidence:

- Ms K, Midwife
- Ms L, Midwife
- Ms M, Labour Ward Coordinator
- Dr N, Paediatric Registrar at the time of events.

11. Dr Mawson provided his own witness statement, dated 11 March 2019, and also gave oral evidence at the hearing.

Expert Witness Evidence

12. The Tribunal received evidence from the GMC expert witness, Dr O, Consultant Obstetrician and Gynaecologist, who provided an expert report, dated 3 November 2017 & supplemental reports dated 11 April 2018 and 13 January 2019. He also gave oral evidence by telephone. Dr O was instructed to comment on the clinical care provided by Dr Mawson to Patient A and Patient B and to assist the Tribunal in understanding the professional standards to be expected of a reasonably competent Locum ST5 Registrar in Obstetrics and Gynaecology. Dr O was also asked to provide an opinion on whether Dr Mawson met those standards.
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13. The Tribunal also received evidence from Dr Mawson’s expert witness, Dr P, Consultant Obstetrician and Gynaecologist, who provided an expert report, dated 15 March 2019, and gave oral evidence by telephone. Dr P was instructed to comment on the standard of care provided by Dr Mawson and whether the care fell below the standard of a reasonably competent ST5 Registrar in Obstetrics and Gynaecology.

14. The experts also provided a joint report, dated 25 March 2019.

Documentary Evidence

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

- Dr Mawson’s statement to the Trust, dated 19 March 2017
- Serious Incident Report and Root Cause Analysis, dated 25 May 2017
- Maternity Service Standard Operating Procedure, dated March 2017
- Maternity Assessment Centre (MAC) Standard Operating Procedure, dated April 2014
- Guidelines for the Prevention and Management of Pre-Term Labour, dated May 2014 and February 2017
- Guidelines for Resuscitation and initial care of Babies Born Extreme Preterm at Less than 26 Weeks Gestation, undated.

The Tribunal’s Approach

16. 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 Mawson 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 as alleged.

17. The Legally Qualified Chair referred the Tribunal to the Supreme Court judgment in the case of Ivey v Genting Casinos (UK) Limited [2017] UKSC 67, in which Lord Hughes set out the correct test for dishonesty, which is as follows:

‘When dishonesty is in question the fact-finding tribunal must first ascertain (subjectively) the actual state of the individual’s knowledge or belief as to the facts. The reasonableness or otherwise of his belief is a matter of evidence (often in practice determinative) going to whether he held the belief, but it is not an additional requirement that his belief must be reasonable; the question is whether it is genuinely held. When once his actual state of mind as to knowledge or belief as to facts is established, the question whether his conduct was honest or dishonest is to be determined by the fact-finder by applying the (objective) standards of ordinary decent people. There is no requirement that
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the defendant must appreciate that what he has done is, by those standards, dishonest.’

The Tribunal’s Analysis of the Evidence and Findings

18. 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.

19. At 03:50 on 18 March 2017, Patient A attended the Maternity Assessment Centre (MAC) at Calderdale Royal Hospital, following a referral from the Accident and Emergency (A&E) at Huddersfield Royal Infirmary. Patient A had presented at A&E complaining of period-like pain of some hours’ duration and vaginal bleeding which had begun about an hour before. On this date Patient A was, according to her 15 week ‘dating scan’, at a gestation of exactly 23 weeks.

20. At 03:55 Dr Mawson attended to review Patient A. However, before he had an opportunity to review her he was called away to review an emergency gynaecology patient who may have needed a referral to theatre. At 04:55 Patient A was assessed by a junior trainee in Obstetrics and a speculum examination was performed which indicated that Patient A may be in labour. Patient A was advised of the findings and informed that the Registrar, Dr Mawson, would be informed.

21. Patient A was moved from the MAC to room 2 on the Labour Ward, known to staff as the ‘bereavement room’.

22. Dr Mawson reviewed Patient A in room 2 at 05:15 and confirmed that she was in established pre-term labour, which was too advanced to be delayed.

Paragraph 1(a)(i)

23. The Tribunal noted that the statement ‘not for intervention at birth due to gestation’ appears in the entry made by Dr Mawson in Patient A’s records, following his review at 05:15.

24. In his witness statement, dated 7 March 2019, Dr Mawson stated that his discussion with Patient A related to ‘intervening in the delivery to prevent or slow the labour process, for example by way of rescue cerclage (insertion of a stitch) or tocolysis (medication to prevent labour from progressing)’. He further stated that his discussion also focussed on whether there was anything he could do in assisting the birth/delivery, including ventouse, caesarean section or other active obstetric interventions. However, he stated that at that ‘gestation and in advancing labour those options are not deemed to be in the best interests of either patient’.

25. In his statement to the Trust, dated 19 March 2017, Dr Mawson stated that after reviewing Patient A he offered his condolences and explained that it appeared
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to be a pre-term labour. He stated that he had a long discussion with the parents and explained that although the fetal heartbeat was present, the baby may not survive labour at 23 weeks gestation. Dr Mawson further stated:

‘I discussed that at 23 weeks the baby is very small and may have a poor outcome and for that reason it is always important to offer supportive care to mothers and babies at delivery, but intervention in terms of babies who need resuscitation is not always advisable or indicated...Upon leaving the room I informed the coordinator that I had seen Patient A and that the diagnosis was pre-term labour at 23 weeks gestation. I explained to the parents that I thought the outcome for baby would be poor due to extreme prematurity and that, in such a situation, intervention at birth is not always beneficial.’

26. The Tribunal had regard to the joint expert report. Both experts agreed that if Dr Mawson meant that no ‘obstetric’ intervention, such as caesarean section, should occur during labour then Dr Mawson’s advice was appropriate as there were no obstetric interventions that he could have undertaken.

27. The experts were also in agreement that if the statement meant that Patient B was not to be actively resuscitated following birth, then this was inappropriate as the decision about the level of intervention required by a baby of this gestation should be made by a paediatrician, not an obstetrician.

28. The Tribunal had regard to the statement of Ms F, dated 23 March 2017, in which she stated:

‘He informed Patient A at this point that although the fetal heart could be seen on the scan, the baby would not be resuscitated at delivery as the gestation was 23/40 and the likely outcome poor’.

29. The Tribunal also had regard to Dr Mawson’s entry in Patient A’s records which stated:

‘...Discussed expected outcome of delivery at 23/40 very poor – baby may not survive labour. Before point of viability...’

30. When asked about the meaning of the term ‘before point of viability’, both experts accepted that it related to Patient B. The Tribunal accepted Mr O’s oral evidence that the entry ‘before point of viability’ meant that the baby was too premature to survive – ie that it could not possibly survive. Dr P was less clear about the precise meaning of that term.

31. Having considered the evidence of both experts and having had the opportunity to question Dr Mawson in person, the Tribunal was not satisfied that the term ‘not for intervention at birth’ related to Patient A. The Tribunal was satisfied
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that Dr Mawson’s entry related to intervention on Patient B. It was also satisfied that the decision about the level of intervention required by a baby of 23 weeks gestation should be made by a paediatrician, not an obstetrician.

32. Having considered the evidence, the Tribunal was satisfied that Dr Mawson inappropriately counselled Patient A that Patient B was 'not for intervention at birth due to gestation'. Accordingly, it found this sub-paragraph of the Allegation proved.

Paragraph 1(a)(ii)

33. Although the medical record made by Ms F at 07:18 refers to the neonatal team not attending the birth, there is otherwise no evidence before the Tribunal, either direct or indirect, to indicate that Dr Mawson had counselled Patient A that there should be no input from paediatrics. The Tribunal noted that during cross-examination, Ms F confirmed that she could not recall any discussion about paediatrics and there is no reference to it her witness statement or in her statement to the Trust.

34. Having considered the evidence, the Tribunal was not satisfied that Dr Mawson inappropriately counselled Patient A that there should be no input from paediatrics. Accordingly, it found this sub-paragraph of the Allegation not proved.

Paragraph 1(d)(i)(1) & (2)

35. The Tribunal made no distinction between labour and birth when considering these sub-paragraphs of the Allegation.

36. The Tribunal had regard to Mr O’s initial report in which he states that Dr Mawson’s original entry suggests that Dr Mawson felt that paediatric intervention at the time of delivery would not be appropriate due to the very early gestation. Mr O stated that this interpretation is supported by Dr Mawson’s comment, ‘...baby may not survive labour. Before point of viability...’. Mr O noted that the Epicure figures, quoted in the Trust’s Root Cause Analysis report, showed that in fact 15% of cases of premature labour at 23 weeks result in delivery of a baby that will survive, and that 29% of 23 week babies who stay alive long enough to be admitted to a neonatal unit will survive. During cross-examination Dr Mawson accepted that he realised there could be a live birth when he detected a fetal heartbeat.

37. Having considered the evidence, the Tribunal was satisfied that the entry made by Dr Mawson in Patient A’s record was inappropriate as it was possible that Patient B would survive labour/birth. Accordingly, it found these sub-paragraphs of the Allegation proved.

Paragraph 1(d)(ii)(1)
38. The Tribunal had regard to the evidence of Mr J, who was the consultant on call at the time of Patient A’s admission. In his GMC witness statement, Mr J stated that he went to see Dr Mawson on the labour ward to discuss another patient when Dr Mawson told him about Patient A. Dr Mawson told him that Patient A was 23 weeks pregnant and had presented with vaginal bleeding, bulging membranes and that the baby’s head was in mid vagina. Mr J stated that they briefly discussed the possible obstetric interventions and both agreed that there was no indication for active obstetric management. Mr J stated that the conversation was short as he was on his way to theatre.

39. Mr J stated that neonatal resuscitation was not discussed with him and that at no point did they discuss involving the neonatal and/or the paediatric team. However, he stated that Trust guidelines were clear that paediatricians should be involved in all deliveries between 23 and 24 weeks.

40. The Tribunal had regard to Dr Mawson’s statement to the Trust, in which he stated:

‘After documenting in Patient A’s notes, I went back to gynaecology theatre, at which time it was approximately 06:20. I discussed Patient A with Mr J including what I had found on USS (ultrasound scan) and VE (vaginal examination) and the discussion regarding my thoughts of expected poor outcome for 23 week babies.’

41. In his witness statement, Dr Mawson expanded on his discussions with Mr J regarding Patient A as follows:

‘A discussion on the ward took place after I had seen Patient A and before I assisted Mr A in gynaecology theatre. I recall we were outside Patient A’s room, Dr D was present and I think Midwife I, the Labour Ward co-ordinator was also there. I told Mr J my findings and that I had carried out an USS and elicited a heartbeat. I clearly remember stating that Patient A was not suitable for a stitch and that I asked Mr J whether or not he wanted to see Patient A. I also believe that I said that the likely outcome for Patient B was poor and that if the baby was born in a poor condition resuscitation might not be indicated. Mr A did not wish to personally review Patient A and I felt he seemed to want to get to theatre. He did not ask any questions of me regarding Patient A or the information which I had presented, nor did he give me further direction into the management of Patient A or B.’

42. Dr Mawson accepted that this discussion was not documented in his statement to the Trust which referred only to a ‘discussion regarding [his] thoughts of expected poor outcome for 23 week babies’. Dr Mawson’s statement to the Trust accords with Mr J’s recollection of the conversation.
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43. Having determined that Dr Mawson’s entry ‘not for intervention at birth due to gestation’ related to the care of Patient B, and having considered the evidence, the Tribunal was satisfied that Dr Mawson’s entry was inappropriate as he had not discussed Patient B’s care with the consultant on call. Accordingly, it found this paragraph of the Allegation proved.

Paragraph 1(d)(ii)(2)

44. Dr Mawson accepted that he had not discussed Patient B’s care with a paediatrician or neonatologist. The Tribunal accepted the expert evidence that he should have done so as it was not within his remit to make a decision regarding resuscitation of Patient B.

45. Having determined that Dr Mawson’s entry ‘not for intervention at birth due to gestation’ related to the care of Patient B, and having considered the evidence, the Tribunal was satisfied that Dr Mawson’s entry was inappropriate as he had not discussed Patient B’s care with a paediatrician or neonatologist. Accordingly, it found this sub-paragraph of the Allegation proved.

Paragraph 2

46. Dr Mawson has admitted that he altered his medical record entry of his 05:15 review of Patient A from ‘not for intervention at birth due to gestation’ to ‘not for resuscitation at birth if unwell due to gestation. Mr A aware of events and agree’. He has also accepted that he made the entry after being informed that Patient B had been born with signs of life and had showed signs of life following birth. However, he disputed that his amendment did not accurately reflect his instructions as contained in the original record.

47. In his statement to the Trust, Dr Mawson explained that, due to being required in theatre, the information that he originally documented was a ‘shortened version of the actual discussion that took place...without further elaboration’. He stated that his original documentation did not adequately summarise the entirety of the consultation and that given an earlier opportunity, he would have added a much more thorough and detailed account. He apologised for any confusion caused by his original documentation.

48. Dr Mawson stated that at approximately 07:25, as he was on his way to the obstetric theatre with another patient, he was subjected to an unpleasant challenge from Ms G about the standard of care he had provided to Patient A. She informed him that Patient A had delivered her baby and that there had been no paediatric involvement. Ms G implied that the care may have been different had it been a member of Dr Mawson’s family. He stated that he proceeded to theatre and finished the procedure at approximately 08:55.
In his witness statement, Dr Mawson stated:

‘I was then in theatre until just before 0900 hours and was writing up my operation notes when another midwife came in and informed me that Patient B had been born alive and there had been "a mess up" and the baby was now dead. I was extremely upset by this and went back to review Patient A’s notes.’

On reviewing the notes he stated that he felt ‘very upset, emotional and fearful at what had been documented without [his] knowledge and without discussion with [him]’ and referred to the following entries in the notes:

‘earlier been discussed by registrar...that neonatal team will not attend birth...

[midwife] left room to discuss with registrar and the decision is confirmed that no neonatal doctor is required as gestation is less than 24 weeks’.

The Tribunal noted that Ms G confirmed in oral evidence that the discussion with Dr Mawson referred to in the medical records at 07:18 had not occurred.

Dr Mawson stated that due to his ‘state of mind and without due consideration’ he edited the previous entry to ‘fully reflect the discussion that occurred with Patient A’.

The Tribunal has already found that Dr Mawson’s original entry related to intervention on Patient B at birth and not to obstetric intervention on Patient A as Dr Mawson maintains. The amended entry clearly relates to neonatal care and makes reference to resuscitation which was not referred to in the original entry. The Tribunal was satisfied that the amended version does not accurately reflect his instructions as contained in the original record.

Having considered the evidence, the Tribunal was satisfied that Dr Mawson altered the record after having been informed that Patient B had been born with signs of life and had showed signs of life following birth and that the altered record did not accurately reflect his instructions as contained in the original record. Accordingly, it found this paragraph of the Allegation proved.

In considering whether Dr Mawson’s actions in altering the record were dishonest, the Tribunal first considered what was in his mind at the time and whether it was a genuinely held belief.

Dr Mawson stated that he edited the previous entry to ‘fully reflect the discussion that occurred with Patient A’. However, he accepted that, in retrospect,
his alteration appeared to change the meaning of his original entry. Dr Mawson stated that he was fully aware that any edits made to the records were easily tracked and he denied that his alteration was an attempt to hide what had occurred or to shift any blame away from him.

57. The Tribunal considered that Dr Mawson’s original entry was quite definite in stating that there was to be no intervention at birth due to gestation. However, his amendment changes the entry to ‘not for resuscitation if unwell due to gestation’ which suggests that Dr Mawson had considered the possibility of neonatal care. The amendment also includes a note to say that Mr J was ‘aware of events’ and agreed.

58. The Tribunal accepted that Mr J was in agreement with Dr Mawson’s management plan for Patient A overall as he had discussed it with him. However, the Tribunal has found that that Dr Mawson did not specifically discuss Patient B’s care with Mr J. Therefore, Mr J could not have agreed as is suggested in the altered record. As written, Dr Mawson’s amended entry suggests that he had.

59. The Tribunal accepted Dr Mawson’s evidence that he was aware that alterations to the record could be tracked and it noted his assertion that he had amended the entry for clarity. In his oral evidence, Dr Mawson accepted that the altered entry made the position less clear. Having considered all the evidence, the Tribunal was satisfied that his amendment was a fundamental change made for the purpose of lessening his own culpability and sharing accountability and not for the purpose of providing clarification.

60. The Tribunal was satisfied that, by the standards of ordinary decent people altering the medical record with that purpose in mind would be considered dishonest. The Tribunal found Dr Mawson’s conduct to be dishonest. Accordingly, it found this paragraph of the Allegation proved.

**The Tribunal’s Overall Determination on the Facts**

61. The Tribunal has determined the facts as follows:

1. On 18 March 2017 you assessed Patient A (‘the Assessment’) and you:
   a. failed to discuss with Patient A the level of intervention and resuscitation that Patient B should undergo at the time of birth;
   b. a. inappropriately counselled Patient A that:
      i. Patient B was ‘not for intervention at birth due to gestation’; **Determined and found proved**
      ii. there should be no input from paediatrics; **Not proved**
e. failed to discuss with the on call consultant or Senior Obstetrician whether and how to monitor Patient B’s heart rate during labour;

b. failed to discuss with the on call consultant or Senior Obstetrician:
   i. whether and how to monitor Patient B’s heart rate during labour; Admitted and found proved as amended
   ii. the option of administering steroid injections to improve Patient B’s lung maturity; Admitted and found proved as amended

d c. failed to contact, or request that the midwifery team contact, a Paediatrician or Neonatologist to discuss with Patient A:
   i. the level of intervention (including options for possible resuscitation) that Patient B should undergo at the time of birth; Admitted and found proved as amended
   iii. the survival rates of very pre-term infants; Admitted and found proved as amended
   ii. the option of administering steroid injections to improve Patient B’s lung maturity;
   iii. possible short and long term consequences of Patient B’s prematurity; Admitted and found proved as amended
   iv. the options for possible resuscitation of Patient B;

e d. recorded that Patient B was ‘not for intervention at birth due to gestation’ which was inappropriate because:
   i. it was possible that Patient B would survive
      1. labour; Determined and found proved
      2. birth; Determined and found proved
   ii. you had not discussed Patient B’s care with:
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1. the consultant on call; **Determined and found proved**

2. a paediatrician or neonatologist; **Determined and found proved**

3. a neonatologist;

   e. at 09:05 you altered your 05:15 record entry from ‘not for intervention at birth due to gestation’ (‘the original record’) to ‘not for resuscitation at birth if unwell due to gestation. Mr A aware of events and agree’ (‘the altered record’). **Admitted and found proved as amended**

2. You made the altered record, after having been informed that Patient B was born with signs of life and had showed signs of life following birth, which did not accurately reflect your instructions as contained in the original record. **Determined and found proved**

3. Your actions as described at paragraph 1e were dishonest by reason of paragraph 2. **Determined and found proved**

**Determination on Impairment - 23/04/2019**

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

**The Evidence**

2. 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 further evidence as follows:

- evidence of case based discussions
- testimonials from Dr Mawson’s professional colleagues
- Dr Mawson’s reflective statements, dated 18 September 2017 and 1 February 2018
- reports for record keeping audits dated 14 March 2018, 29 March 2018 and 16 May 2018
- formative Mini-CEX (Clinical Evaluation Exercise) – Obstetrics, dated 29 May 2018
- multi-source feedback spanning the period 12 to 30 May 2018
- Team Observation Summaries dated 9 May 2018, 30 May 2018, 5 February 2019
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- Annual Review of Competency Progression, dated 26 June 2018
- evidence of Continuing Professional Development (CPD).

3. In addition, the Tribunal received testimonial evidence from the following witness on Dr Mawson’s behalf:

- Dr Q, Consultant Obstetrician and Gynaecologist, Leeds Teaching Hospitals NHS Trust and Head of School of Obstetrics and Gynaecology, Health Education England Yorkshire and the Humber, in person.

Submissions

4. On behalf of the GMC, Ms Barlow submitted that the proven facts in this case amount to serious misconduct and that Dr Mawson’s fitness to practise is impaired as a result.

5. Ms Barlow submitted that Dr Mawson’s conduct fell seriously below the standards expected of him, both in regard to his clinical failings, specifically the failure to involve the paediatric department, and his dishonesty.

6. In respect of Dr Mawson’s clinical failings, Ms Barlow accepted that they related to a single clinical episode and involved failings of others. However she submitted that there were multiple failings on Dr Mawson’s part which he attempted to conceal. Ms Barlow submitted that it was clear that Dr Mawson was not aware of the guidelines relating to the viability of a 23 week fetus, that Patient B was born alive and death was not inevitable.

7. In respect of Dr Mawson’s dishonesty, Ms Barlow acknowledged that there was a ‘plethora’ of evidence in respect of remediation. However, she submitted that there is no evidence of reflection in relation to dishonesty as Dr Mawson has denied throughout that his conduct in altering the record had been dishonest. Ms Barlow submitted that as a result he cannot have insight in relation to his dishonesty.

8. Finally, Ms Barlow submitted that the public interest would be undermined if a finding of impairment was not made in this case.

9. On behalf of Dr Mawson, Mr Partridge submitted that the question of impairment is a matter for the Tribunal.

The Relevant Legal Principles

10. 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.
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11. The Legally Qualified Chair referred the Tribunal to the definition of misconduct, as set out in the case of *Roylance v General Medical Council (No.2) [2000] 1 AC 311 (UKPC)*, which is as follows:

‘Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a [medical] practitioner in the particular circumstances. The misconduct is qualified in two respects. First, it is qualified by the word “professional” which links the misconduct to the profession [of medicine]. Secondly, the misconduct is qualified by the word “serious”. It is not any professional misconduct which would qualify. The professional misconduct must be serious.’

12. 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 which was serious and then whether the finding of serious misconduct could lead to a finding of impairment.

13. The Tribunal must determine whether Dr Mawson’s fitness to practise is impaired today, taking into account Dr Mawson’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

14. The Tribunal first considered whether the facts as found proved amounted to misconduct. The Tribunal categorised Dr Mawson’s alleged misconduct as follows:

- his clinical failings in respect of Patient A and Patient B
- his dishonesty.

Clinical failings

Sub-paragraph 1(a)(i)

15. The Tribunal has found, as set out at sub-paragraph 1(a)(i) of the Allegation, that Dr Mawson inappropriately counselled Patient A that Patient B was not for intervention at birth due to gestation.

16. Both experts were in agreement that the decision about the level of intervention required by a baby of that gestation should be made by a paediatrician, not an obstetrician. Dr O was of the opinion that Dr Mawson’s conduct was seriously below the standard to be expected of reasonably competent Locum ST5 Registrar in
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Obstetrics and Gynaecology as it implied a significant lack of knowledge about possible survival at 23 weeks’ gestation and an overconfidence in his own knowledge. In the joint expert report, Dr O stated that Dr Mawson mistakenly assumed, on his own authority, and without actively seeking advice, that a baby born at 23 weeks’ gestation could not possibly survive.

17. The Tribunal had regard to the GMC’s guidance, Good medical practice (2013) (GMP) and, in particular, paragraphs 8, 11, 14, sub-paragraph 15(b) and (c) and paragraph 68 which state:

8. You must keep your professional knowledge and skills up to date.

11. You must be familiar with guidelines and developments that affect your work.

14. You must recognise and work within the limits of your competence.

15. You must provide a good standard of practice and care. If you assess, diagnose or treat patients, you must...

b. promptly provide or arrange suitable advice, investigations or treatment where necessary

c. refer a patient to another practitioner when this serves the patient’s needs.

68. You must be honest and trustworthy in all your communication with patients and colleagues. This means you must make clear the limits of your knowledge and make reasonable checks to make sure any information you give is accurate.’

18. The Tribunal was satisfied that Dr Mawson’s conduct was seriously below the standard expected and clearly breached the principles set out in GMP as referred to above.

19. Having considered the expert evidence and the guidance set out in GMP, the Tribunal concluded that Dr Mawson’s standard of care fell so far short of the standards expected of a reasonably competent Locum ST5 Registrar in Obstetrics and Gynaecology as to amount to misconduct that was serious.

Sub-paragraphs 1(b)(i - ii)

20. Dr Mawson has admitted, as set out at sub-paragraphs 1(b)(i - ii) of the Allegation, that he failed to discuss with the on call consultant or senior obstetrician
whether and how to monitor Patient B’s heart rate during labour and the option of administering steroid injections to improve Patient B’s lung maturity.

21. Both experts were in agreement that Dr Mawson should have discussed these aspects of care with the on call consultant in keeping with local and national guidelines. Dr O considered that this was below but not seriously below the standard to be expected of reasonably competent Locum ST5 Registrar in Obstetrics and Gynaecology. However, in their joint report both experts agreed that if Dr Mawson had not initiated this discussion then Mr J, the consultant on call, should have. The Tribunal had regard to Mr J’s oral evidence in which he stated that, notwithstanding the guidelines, they would not monitor the heart rate or administer steroids for a baby of 23 weeks gestation.

22. Having considered the evidence, the Tribunal was satisfied that Dr Mawson’s failure to discuss these matters with the on call consultant or a senior obstetrician was not sufficiently serious as to amount to misconduct.

Sub-paragraphs 1(c)(i – iii)

23. Dr Mawson has admitted, as set out at sub-paragraphs 1(c)(i - iii) that he failed to contact, or request that the midwifery team contact, a paediatrician or neonatologist to discuss with Patient A: the level of intervention (including options for possible resuscitation) that Patient B should undergo at the time of birth; the survival rates of very pre-term infants and the possible short and long term consequences of Patient B’s prematurity.

24. Both experts were in agreement that Dr Mawson had a duty to ensure that a paediatrician/neonatologist was informed about Patient A’s case so that they could undertake the appropriate discussions with Patient A about the care to be provided to Patient B. Dr O was of the opinion that Dr Mawson’s conduct was seriously below the standard to be expected of reasonably competent Locum ST5 Registrar in Obstetrics and Gynaecology.

25. The Tribunal had regard to paragraph 11 and sub-paragraph 15(c) of GMP, as quoted above. It was satisfied that Dr Mawson’s failure to ensure that a paediatrician/neonatologist was informed about Patient A’s case was serious and clearly breached the principles set out in GMP.

26. Having considered the expert evidence and the guidance set out in GMP, the Tribunal concluded that Dr Mawson’s standard of care fell so far short of the standards expected of a reasonably competent Locum ST5 Registrar in Obstetrics and Gynaecology as to amount to misconduct that was serious.

Sub-paragraphs 1(d)(i - ii)
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27. The Tribunal has found, as set out at sub-paragraphs 1(d)(i - ii) of the Allegation, that Dr Mawson’s record that Patient B was not for intervention at birth due to gestation was inappropriate as it was possible that Patient B would survive labour/birth and Dr Mawson had not discussed Patient B’s care with the consultant on call or a paediatrician/neonatologist.

28. The Tribunal had regard to the Epicure figures, quoted in the Trust’s Root Cause Analysis report, which showed that 15% of cases of premature labour at 23 weeks result in delivery of a baby that will survive, and that 29% of 23 week babies who stay alive long enough to be admitted to a neonatal unit will survive. The Trust guidelines also state that babies of this gestation could survive.

29. For Dr Mawson to have made the decision that Patient B was to receive no intervention at birth, particularly without having discussed this with paediatric or neonatal colleagues, was a serious failing in care and professional standards. Although specific advice on the care of Patient B is not the remit of the consultant obstetrician on call, the management plan for Patient A, including involvement of the paediatric team should have formed part of Dr Mawson’s discussion with him.

30. The Tribunal had regard to paragraph 14 and sub-paragraphs 15(b) and (c) of GMP as quoted above, in addition to sub-paragraph 16(d), which states:

‘16. In providing clinical care you must...

d. consult colleagues where appropriate...’.

31. Having considered the expert evidence and the guidance set out in GMP, the Tribunal concluded that Dr Mawson’s standard of care fell so far short of the standards expected of a reasonably competent Locum ST5 Registrar in Obstetrics and Gynaecology as to amount to misconduct that was serious.

Sub-paragraph 1(e) and paragraph 2

32. Dr Mawson has admitted, as set out at sub-paragraph 1(e) of the Allegation, that he altered his original entry in Patient A’s notes regarding intervention. The Tribunal has found, at paragraph 2 of the Allegation, that he did so after having been informed that Patient B was born with signs of life and had showed signs of life following birth. Additionally, the altered note did not accurately reflect his instructions as contained within the original record.

33. The Tribunal had regard to Dr O’s initial expert report, dated 3 November 2017, in which he stated that alteration of a contemporaneous medical record retrospectively, for whatever reason is completely wrong. He was of the opinion that Dr Mawson’s conduct was seriously below the standard to be expected of reasonably competent Locum ST5 Registrar in Obstetrics and Gynaecology.
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34. The Tribunal had regard to paragraph 19 of GMP, which states:

‘19. Documents you make (including clinical records) to formally record your work must be clear, accurate and legible. You should make records at the same time as the events you are recording or as soon as possible afterwards.’

35. Having considered the expert evidence and the guidance set out in GMP, the Tribunal concluded that Dr Mawson’s conduct fell so far short of the standards expected as to amount to misconduct that was serious.

Dishonesty

Paragraph 3

36. The Tribunal has found, as set out at paragraph 3 of the Allegation, that Dr Mawson’s alteration of his original entry was dishonest. The Tribunal has already determined that Dr Mawson’s amendment was a fundamental change to the record which was made for the purposes of lessening his own culpability and sharing accountability.

37. The Tribunal had regard to GMP and in particular the duty of a doctor registered with the General Medical Council to be honest and open and to act with integrity. It also had regard to paragraphs 36, 65 and 71 which state:

‘36. You must treat colleagues fairly and with respect.

65. You must make sure that your conduct justifies your patients’ trust in you and the public’s trust in the profession.

71. You must be honest and trustworthy when writing reports, and when completing or signing forms, reports and other documents. You must make sure that any documents you sign or write are not false or misleading.

a. You must take reasonable steps to check the information is correct...’

38. The Tribunal was satisfied that Dr Mawson’s conduct, which was directly related to his professional practice, was serious and clearly breached the principles set out in GMP as referred to above.

39. Having considered the guidance, the Tribunal concluded that Dr Mawson’s conduct fell so far short of the standards expected as to amount to misconduct that was serious.
Impairment

40. Having found misconduct, as set out above, the Tribunal went on to consider whether, as a result of that misconduct, Dr Mawson’s fitness to practise is currently impaired.

Clinical failings

41. In relation to Dr Mawson’s clinical failings, the Tribunal noted that although they were several, they arose from a single clinical decision not to involve the paediatric team, meaning that no appropriate management plan for the care of Patient B was formulated. This was based on the mistaken understanding that babies born at 23 weeks gestation were not viable.

42. The Tribunal had regard to the Trust Serious Incident and Root Cause Analysis report which noted that there were significant team factors contributing to the incident. It also noted that there were problems with clinical and managerial leadership. The investigation found that deficiencies in communication between different members of staff and a failure to consult guidelines had also contributed to the incident. The report stated:

‘Staff directly involved in this case had insufficient clinical experience and knowledge of the management of an extremely premature delivery. Guidelines to aid their decision making were in place but were not consulted as a belief was in place that no intervention would take place for a baby born before 24 weeks of gestation.’

43. The Tribunal was satisfied that Dr Mawson’s misconduct in respect of his clinical failings is remediable and the evidence before the Tribunal demonstrates that it has been remediated. It is apparent that Dr Mawson has reflected extensively on his failings and has undertaken relevant case based discussions and CPD learning designed to address them. The testimonials before the Tribunal speak to the high regard in which he is held as a clinician. As a result of the evidence of remediation and reflection, the testimonial evidence and the opinion expressed in the joint expert report, the Tribunal was satisfied that any risk of repetition was negligible.

44. The Tribunal has also borne in mind the statutory overarching objective which is to protect the public. This includes: to protect and promote the health, safety and wellbeing of the public and to promote and maintain public confidence in the medical profession.

45. Having considered the particular context in which Dr Mawson’s clinical failings occurred, the Tribunal was satisfied that public confidence in the profession would not be undermined if a finding of impairment were not made in relation to those
clinical findings. Accordingly, the Tribunal has determined that Dr Mawson’s fitness to practise is not currently impaired by reason of misconduct arising from his clinical failings.

**Dishonesty**

46. In relation to Dr Mawson’s dishonesty, the Tribunal was mindful that dishonesty may be difficult to remediate. However, there is no evidence before the Tribunal that Dr Mawson has undertaken any remediation or reflection in relation to his dishonesty given that he has maintained that he altered his original record for the purpose of clarification and was not dishonest.

47. In the absence of any tangible evidence of insight, remediation or reflection on the specific finding of dishonesty, the Tribunal determined that Dr Mawson’s fitness to practise is currently impaired. In addition, the Tribunal considered that public confidence in the profession and the maintenance of proper professional standards and conduct for members of the profession would be undermined if a finding of impairment was not made in the particular circumstances of this case.

48. Having considered all the circumstances, the Tribunal has determined that Dr Mawson’s fitness to practise is impaired by reason of misconduct.

**Determination on Sanction - 24/04/2019**

1. Having determined that Dr Mawson’s fitness to practise is impaired by reason of misconduct, the Tribunal now has to decide in accordance with Rule 17(2)(n) of the Rules on the appropriate sanction, if any, to impose.

**The Evidence**

2. The Tribunal has taken into account all the evidence received during the earlier stages of the hearing where relevant to reaching a decision on sanction.

**Submissions**

3. On behalf of the GMC, Ms Barlow submitted that the appropriate sanction in this case is a period of suspension. She stated that a period of suspension would uphold public confidence in the profession and maintain proper professional standards and conduct for members of the profession. Ms Barlow referred the Tribunal to paragraph 91 of the Sanctions Guidance (February 2018) (SG), which states:

‘91 Suspension has a deterrent effect and can be used to send out a signal to the doctor, the profession and public about what is regarded as behaviour unbefitting a registered doctor. Suspension from the medical register also has
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a punitive effect, in that it prevents the doctor from practising (and therefore from earning a living as a doctor) during the suspension, although this is not its intention.’

4. Ms Barlow submitted that suspension would send a clear signal to the profession and the public that dishonest misconduct would not be tolerated.

5. Ms Barlow stated that there were no aggravating features in this case over and above the Tribunal’s finding that Dr Mawson’s fitness to practise is impaired by reason of his dishonesty. She accepted that there is extensive mitigation before the Tribunal, as set out in Dr O’s expert report.

6. Ms Barlow submitted that taking no action in Dr Mawson’s case would be inappropriate as there are no exceptional circumstances to warrant it. She further submitted that a period of conditional registration would be inappropriate in light of the Tribunal’s finding of dishonesty. She made no submissions in respect of erasure.

7. On behalf of Dr Mawson, Mr Partridge accepted that a period of suspension would be the appropriate sanction in this case.

8. Mr Partridge submitted that since receiving the Tribunal’s determination on Facts, Dr Mawson has had the opportunity to reflect and is ‘deeply ashamed’ and ‘mortified’. On Dr Mawson’s behalf Mr Partridge apologised to the profession, this Tribunal, Dr Mawson’s colleagues, in particular Mr J, and patients A and B.

9. Mr Partridge submitted that the evidence before the Tribunal shows that Dr Mawson’s dishonesty was entirely out of character. He referred the Tribunal to the testimonials from Dr Mawson’s colleagues, some of whom he has worked with for a number of years, who stated that they have no doubts about his honesty and probity. Mr Partridge referred to the evidence that Dr Mawson is considered an outstanding trainee doctor. He submitted that it is important to look at his misconduct in the context of the index events and lack of support.

10. Mr Partridge submitted that the testimonials before the Tribunal demonstrate that Dr Mawson immediately took steps to remediate the areas in which he was deficient and that this can also be seen in his reflective statements and the focussed case based discussions.

11. Mr Partridge made the Tribunal aware that Dr Mawson is at a critical point in his training, undertaking Advanced Training Modules. He submitted that a prolonged period of suspension could affect the acquisition of new skills.

12. Mr Partridge stated that there are no aggravating factors in this case. He identified the following mitigating factors:
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- Dr Mawson’s general character and attitude
- the fact that he has the support of his professional colleagues.

13. Mr Partridge submitted that the Tribunal could be assured that there would be no repetition of Dr Mawson’s dishonest conduct.

The Tribunal’s Determination on Sanction

14. The decision as to the appropriate sanction to impose, if any, is a matter for this Tribunal exercising its own judgement. In reaching its decision, the Tribunal took account of the SG. It has borne in mind that although sanctions are not imposed to punish a doctor, they may have a punitive effect.

15. Throughout its deliberations, the Tribunal had regard to the principle of proportionality and weighed the interests of the public with Dr Mawson’s interests.

Aggravating and mitigating factors

16. The Tribunal considered whether there were any aggravating or mitigating factors in Dr Mawson’s case. Although both Ms Barlow and Ms Partridge stated that there were no aggravating factors in this case, the Tribunal had regard to paragraph 51 and sub-paragraphs 52(a) and (c) of the SG which state:

’51 It is important for tribunals to consider insight, or lack of, when determining sanctions. It is particularly important in cases whether the doctor and the GMC agree undertakings or the tribunal imposes conditions. The tribunal must be assured that this approach adequately protects patients, in that the doctor has recognised the steps they need to take to limit their practice to remediate.

52 A doctor is likely to lack insight if they:

a refuse to apologise or accept their mistakes...

c do not demonstrate the timely development of insight…’.

17. The Tribunal was concerned that Dr Mawson’s acknowledgement of his dishonesty and apology for that dishonesty was only expressed in submissions on his behalf in relation to sanction. The Tribunal was satisfied that Dr Mawson’s late development of insight in relation to his dishonesty is an aggravating factor in this case.

18. In respect of mitigating factors, the Tribunal noted the submissions from both Counsel and the following as set out in the Trust’s Root Cause Analysis report:
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‘Failure to consult guidelines for rare clinical occurrences

Staff directly involved in this case had insufficient clinical experience and knowledge of the management of an extremely premature delivery. Guidelines to aid their decision making were in place but were not consulted as a belief was in place that no intervention would take place for a baby born below 24 weeks of gestation.

Remote leadership and inappropriate delegation

Delegation to a junior midwife with remote supervision and delayed involvement of senior medical staff resulted in the initial management plan not being questioned. Medical senior leadership had the required knowledge to manage the situation but was contacted late and did not involve themselves sufficiently in the situation to result in a change to the management plan already made.

Unhelpful communication style and documentation

Communication about this case was unclear and did not invite staff involved at a later stage to question decisions already made and implied that decisions had been made with the involvement of all the necessary teams...

Lack of clarity about how to involve the paediatric team

There is clear guidance in place regarding the involvement of the paediatric team on LDRP (Labour/Delivery/Recovery/Postnatal) but this guidance was not followed as the team was unclear whose responsibility the involvement of the paediatric team should be.'

19. In addition, the Tribunal was mindful that Dr Mawson’s alteration of the medical record happened at the end of a very busy night shift, in an environment where he felt unsupported and at a time when he had panicked after being directly challenged by two midwife colleagues about his handling of the case.

Appropriate sanction

20. The Tribunal considered each sanction in ascending order of seriousness, starting with the least restrictive.

No action

21. The Tribunal first considered whether it would be sufficient to conclude Dr Mawson’s case with no action. It determined that taking no action on Dr Mawson’s registration would be wholly inappropriate in a case involving dishonesty. The
Tribunal was also satisfied that there were no exceptional circumstances in Dr Mawson’s case that would warrant it taking no action.

Conditions

22. The Tribunal then considered whether it would be sufficient to impose conditions on Dr Mawson’s registration. It has borne in mind that any conditions imposed should be appropriate, proportionate, workable and measurable. The Tribunal concluded that it would not be possible to formulate appropriate and workable conditions in a case involving dishonesty where it has identified that a doctor lacks insight.

Suspension

23. The Tribunal next considered whether it would be appropriate to suspend Dr Mawson’s registration. The SG, at paragraphs 92, 93 and 97 states:

92 Suspension will be an appropriate response to misconduct that is so serious that action must be taken to protect members of the public and maintain public confidence in the profession. A period of suspension will be appropriate for conduct that is serious but falls short of being fundamentally incompatible with continued registration (ie for which erasure is more likely to be the appropriate sanction because the tribunal considers that the doctor should not practise again either for public safety reasons or to protect the reputation of the profession).

93 Suspension may be appropriate, for example, where there may have been acknowledgement of fault and where the tribunal is satisfied that the behaviour or incident is unlikely to be repeated. The tribunal may wish to see evidence that the doctor has taken steps to mitigate their actions...

97 Some or all of the following factors being present (this list is not exhaustive) would indicate suspension may be appropriate.

   a A serious breach of Good medical practice, but where the doctor’s misconduct is not fundamentally incompatible with their continued registration, therefore complete removal from the medical register would not be in the public interest. However, the breach is serious enough that any sanction lower than a suspension would not be sufficient to protect the public or maintain confidence in doctors.

   b ...

   c ...
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d...

e No evidence that demonstrates remediation is unlikely to be successful, eg because of previous unsuccessful attempts or a doctor’s unwillingness to engage.

f No evidence of repetition of similar behaviour since incident…’

24. The Tribunal had already stated that Dr Mawson’s misconduct, which was directly related to his professional practice, was serious and clearly breached the principles set out in Good medical practice. However, the Tribunal had regard to the mitigating factors in this case. It took into account the fact that Dr Mawson’s dishonest conduct occurred at the end of a busy shift when he felt tired and panicked by entries recorded by the midwives in Patient A’s records which he felt misrepresented the situation.

25. One of those entries stated that, after Patient B had been born alive, a midwife left the room ‘to discuss with Registrar and the decision is confirmed no neonatal doctor is required as gestation is less than 24 weeks’. The evidence is that this entry is inaccurate - no further conversation had taken place with Dr Mawson. In addition the evidence is that there was also a catalogue of missed opportunities by other colleagues, including the consultant on call and the Labour Ward Coordinator, to intervene and ensure the paediatric team had been called.

26. The Tribunal accepted that this appears to have been an isolated instance of dishonesty in Dr Mawson’s medical career and this is borne out by multiple statements in the evidence commenting on his general probity. The Tribunal had no reason to doubt that Dr Mawson is an otherwise honest and trustworthy doctor.

27. Having considered all the evidence, the Tribunal determined that the maintenance of public confidence in the medical profession and the maintenance of proper professional standards and conduct for the members of the profession would be addressed by a sanction of suspension. The Tribunal concluded that a period of suspension would mark the seriousness of Dr Mawson’s misconduct and send the appropriate message to the profession, and the public, about what is regarded as behaviour unbefitting a registered medical practitioner.

28. The Tribunal determined to suspend Dr Mawson’s registration for a period of two months.

29. In determining the length of the suspension, the Tribunal considered that a period of two months would allow Dr Mawson sufficient time to undertake reflection and remediation in respect of the dishonesty that it has found. It considered this an appropriate period to mark the gravity of the misconduct but also to reflect the
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circumstances in which the incident took place and in light of both the aggravating and mitigating factors it has identified.

30. The Tribunal considered whether it would be appropriate to direct a review hearing in Dr Mawson’s case. It has borne in mind that no doctor should be allowed to resume unrestricted practice following a period of suspension unless the Tribunal considers that they are safe to do so. The Tribunal had regard to paragraph 164 of the SG, which states:

‘164 In some misconduct cases it may be self-evident that, following a short suspension, there will be no value in a review hearing. However, in most cases where a period of suspension is imposed...the tribunal will need to be reassured that the doctor is fit to resume practice – either unrestricted or with conditions...A review hearing is therefore likely to be necessary, so that the tribunal can consider whether the doctor has shown all of the following (by producing objective evidence):

 a they fully appreciate the gravity of the offence
 b they have not reoffended
 c they have maintained their skills and knowledge
 d patients will not be placed at risk by resumption of practice or by the imposition of conditional registration.’

31. The Tribunal noted the significant amount of work Dr Mawson has done to remediate the clinical concerns in this case, much of which was self-initiated and commenced promptly following the incident. The Tribunal was satisfied that this demonstrated Dr Mawson’s ability and preparedness to reflect appropriately in order to remediate areas of concern. It was therefore confident that Dr Mawson would reflect deeply and appropriately on the gravity and impact of the finding of dishonesty during the period of his suspension.

32. In the circumstances, the Tribunal determined that the duration of Dr Mawson’s suspension, the fact that there are no remaining clinical concerns in this case and the fact that it is confident that Dr Mawson will undertake the required reflection and remediation, means that a review hearing is not required.

**Determination on Immediate Order** - 24/04/2019

1. Having determined to suspend Dr Mawson’s registration, the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether Dr Mawson’s registration should be subject to an immediate order.
Submissions

2. On behalf of the GMC, Ms Barlow submitted that there is no requirement for an immediate order in this case.

3. On behalf of Dr Mawson, Mr Partridge submitted that he agrees that there is no requirement for an immediate order.

The Tribunal’s Determination

4. The Tribunal had regard to the relevant paragraphs of the SG. The Tribunal noted that there are no patient safety issues in Dr Mawson’s case. The Tribunal considered that the public interest, specifically the maintenance of public confidence in the medical profession and the maintenance of proper professional standards and conduct for members of the profession, is addressed by its finding of impairment and the imposition of a period of suspension. It has therefore determined that this is not a case where its findings necessitate the imposition of an immediate order.

5. This means that Dr Mawson’s registration will be suspended 28 days from when notice of this decision is deemed to have been served upon him, unless he lodges an appeal. If Dr Mawson does lodge an appeal he will remain free to practise unrestricted until the outcome of any appeal is known.

6. There is no interim order to revoke.

Confirmed
Date 24 April 2019

Mr Damian Cooper, Chair