PUBLIC RECORD

Dates: 20/01/2025 - 05/02/2025

Doctor:	Dr Kazal OMAR
GMC reference number:	4570455
Primary medical qualification:	MB ChB 1980 University of Mosul College of Medicine

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

Summary of outcome

No warning

Tribunal:

Legally Qualified Chair	Mr Lindsay Irvine
Lay Tribunal Member:	Ms Gail Mortimer
Registrant Tribunal Member:	Dr Gillian Livesey

Tribunal Clerk:	Mr Matt O'Reilly

Attendance and Representation:

Doctor:	Present, represented
Doctor's Representative:	Mr Ghazan Mahmood, Counsel, instructed by Hempsons Solicitors
GMC Representative:	Mr Hugh Barton, 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 - 03/02/2025

Background

1. Dr Omar, a Consultant Obstetrician and Gynaecologist, qualified with an MBBS from the University of Mosul, Iraq in 1980. She held the post of Consultant Obstetrician and Gynaecologist, and Lecturer, at Salaheddin Medical School, Erbil, Iraq from 1989 until 1995. She moved to the UK in 1995 where she began her career in the NHS. Dr Omar held a substantive consultant post at the Princess Royal University Hospital in Farnborough, Kent, from 2006 until 2014. She was also a college tutor from 2006 until 2014. Dr Omar held the position of Consultant Obstetrician and Gynaecologist and Clinical Lead for Gynaecology and Oncology at Kings College Hospital NHS Foundation Trust from 2014 until 2023, and currently holds practising privileges for Circle Health Group and the Nuffield, Brentwood.

2. On 16 December 2020, Dr Omar carried out a hysteroscopy and fibroid resection ('the Procedure') on Patient A, at The Sloane Hospital ('the Hospital'), in Beckenham, a private hospital within the Circle Health Group ('CHG'). There were complications during the Procedure and Patient A suffered a significant fluid overload which resulted in complications, namely pulmonary oedema.

3. It is alleged that the operation note of the Procedure was retrospectively altered by Dr Omar, on a date or dates between 16 December 2020 and 6 April 2021; that she overwrote the record of fluid output noted in the operation notes from '5.20' to '7.20L'; and that she arranged for the altered record of the Procedure to be provided to Patient A, and that she was dishonest by reason of these allegations.

4. Patient A was subsequently transferred to an NHS hospital for urgent treatment. There was an internal investigation following the incident and Dr Omar was exonerated of any wrongdoing during the Procedure.

5. At her last consultation with Dr Omar in March 2021 Patient A requested her medical records and the documents relating to her treatment. These were provided to her by Dr Omar's secretary in April 2021. On 25 October 2022 Patient A made a complaint to the GMC and, as part of the GMC's investigation which followed, Patient A forwarded all the documents held by her to the GMC. The GMC also requested that Dr Omar forward all the documentation she had in respect of the treatment of Patient A. The documents sent by Dr Omar to the GMC were three letters, dated 11 November 2020, 16 December 2020 and 31 March 2021, which it is alleged had been written in retrospect in 2022, after the GMC request had been made. It is further alleged that Dr Omar failed to indicate, and knew, that these letters were written in retrospect, the date upon which the letters were actually written, and that the letters had not been sent to Beckenham Beacon.

6. In early 2023 the GMC informed Dr Omar of discrepancies in those three letters and asked her for an explanation. Dr Omar denied any dishonesty but said she had written each of the letters subsequently, in the presence of Ms B, Quality and Risk Manager at The Sloane Hospital based on the records of Patient A held at the hospital. At that point in time, Ms B became a potential witness and the GMC contacted her. It came to the attention of the GMC that Dr Omar had been in recent contact with Ms B regarding the investigation and they wrote to Dr Omar warning her about contact with potential witnesses. The GMC became aware that since the warning not to contact potential witnesses, Dr Omar had emailed Ms B in which she instructed her to supply the GMC with information helpful to her case on the basis that it; *"is better to come from you than me".* It is therefore alleged that the email, coming so soon after clear warnings from the GMC, represented an inappropriate interference with a potential witness and that the email had the potential to influence Ms B, and that she (Dr Omar) knew, or ought to have known, her email had the potential to influence Ms B.

The Outcome of Applications Made during the Facts Stage

7. At the outset of the hearing, the Legally Qualified Chair invited parties to make submissions as to whether there should be an anonymity application in respect of Patient A. Mr Hugh Barton, Counsel on behalf of the GMC, submitted that the bundles were redacted, and that Patient A was entitled to anonymity. Mr Ghazan Mahmood, Counsel on behalf of Dr Omar, made no objection. The Tribunal therefore determined that Patient A's identity should not be revealed to the public and would be referred to as Patient A throughout these proceedings, pursuant to Rule 35(4) of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules').

8. On day 3 of the hearing, Mr Mahmood made an objection to the line of questioning by Mr Barton in his re-examination of the GMC expert, Mr C. The Tribunal therefore heard an application as to the admissibility of evidence. The Tribunal upheld Mr Mahmood's objection and its full written decision can be found at Annex A.

9. On day 3 of the hearing the Tribunal heard submissions from parties in respect of hearsay evidence regarding the witness statement of Ms D. Ms D, a GMC witness, was listed to provide oral evidence during the hearing but the Tribunal were informed by Mr Barton that she would no longer be attending. Neither Mr Barton nor Mr Mahmood objected to the admission of the witness statement. The Tribunal determined that it was fair to allow the written statement of Ms D to be admitted in evidence and resolved to consider carefully what weight should be given to it in the course of its deliberation on the Facts. The Tribunal's full written decision can be found at Annex B.

10. On day 5 of the hearing, following the conclusion of Dr Omar's evidence, the Tribunal invited Mr Mahmood to address it in respect of paragraph 8a of the Allegation, which had been admitted at the outset of the hearing. After hearing all the evidence, it appeared to the Tribunal that the admission made did not accord with Dr Omar's case. Mr Mahmood confirmed that it was not accepted that the content of the letter, dated 16 December 2020, was materially different to the original version of that letter, as alleged at the stem of paragraph 8. Mr Mahmood said paragraph 8a, including the stem, was not therefore admitted. Mr Barton said that he understood that to have been the defence's case, as characterised by Mr Mahmood. Mr Mahmood said that paragraph 8 in its entirety was therefore not admitted. Mr Barton said that it was a matter for the Tribunal as to whether it withdrew the admission. The Tribunal determined that it had understood Dr Omar's case throughout as had been characterised by Mr Mahmood and therefore determined to withdraw the admission and that it was a matter for it to determine.

The Allegation and the Doctor's Response

11. The Allegation made against Dr Omar is as follows:

1. On 16 December 2020 you performed a hysteroscopic resection of fibroid ('the Procedure') upon Patient A during which Patient A developed a fluid overload of approximately four litres. Admitted and found proved

2. On a date or dates between 16 December 2020 and 06 April 2021 you:

    a. retrospectively altered an entry in Patient A's medical records relating to the Procedure in that you overwrote the record of fluid output

noted in the operation/treatment notes from '5.20' to '7.20L';
Admitted and found proved

b. arranged for the altered record of the Procedure described at paragraph 2.a above to be provided to Patient A.
Admitted and found proved

3. When you acted in the manner described at paragraph 2.a you knew that the entry you made was an incorrect record of fluid output during the Procedure.
To be determined

4. When you acted in the manner described at paragraph 2.b you knew that you were providing inaccurate information to Patient A as to the extent of the fluid overload that developed during the Procedure. To be determined

5. Your actions at paragraphs:

a. 2.a were dishonest by reason of paragraph 3;
To be determined

b. 2.b were dishonest by reason of paragraph 4.
To be determined

6. Between a date on or around 22 December 2020 and 8 November 2022 you:

a. rewrote a letter in retrospect dated 11 November 2020 regarding Patient A which was readdressed to Beckenham Beacon;
Admitted and found proved

b. rewrote a letter in retrospect dated 16 December 2020 regarding Patient A which was readdressed to Beckenham Beacon;
Admitted and found proved

c. rewrote a letter in retrospect dated 31 March 2021 regarding Patient A which was readdressed to Beckenham Beacon.
Admitted and found proved

7. When you acted in the manner outlined at paragraphs 6.a-6.c, you:

a. failed to indicate on the letters:
i. that the letters were written in retrospect;
Admitted and found proved

ii. the date upon which the letters were actually written;
Admitted and found proved

iii. that the letters had not been sent to Beckenham Beacon;
Admitted and found proved

b. knew that:

i. the letters were written in retrospect;
Admitted and found proved

ii. the date upon which the letters were actually written was not made clear; To be determined

iii. the letters had not been sent to Beckenham Beacon.
Admitted and found proved

8. When you rewrote the letter as described at paragraph 6.b the content of it was materially different to the original version of that letter and you:

a. failed to indicate on the letter that the content of it was materially different to the original version of that letter;
To be determined

b. knew that the content of it was materially different to the original version of that letter. To be determined

9. On 08 November 2022 you provided a copy of the letters outlined at paragraphs 6.a to 6.c to the GMC. Admitted and found proved

10. When you acted in the manner described at paragraph 9 you:

a. failed to indicate to the GMC when providing a copy of the letters outlined at paragraphs 6.a to 6.c:

i. that the letters were written in retrospect;
Admitted and found proved

ii. the date upon which the letters were actually written;
Admitted and found proved

iii. that the letters had not been sent to Beckenham Beacon;
Admitted and found proved

iv. that the content of the letter at paragraph 6.b. was materially different to the original; To be determined

b. knew the matters outlined in paragraph 7.b and/or 8.b. To be determined

11. Your actions at paragraphs:

a. 6 were dishonest by reason of paragraph 7; To be determined

b. 6.b were also dishonest by reason of paragraph 8; To be determined

c. 9 were dishonest by reason of paragraph 10. To be determined

12. On 06 June 2023 you wrote an email ('the Email') to Ms B as outlined in Schedule One when:

a. the content of the Email had the potential to influence the evidence that Ms B provided to the GMC; To be determined

b. you knew or ought to have known that the content of the Email had the potential to influence the evidence that Ms B provided to the GMC. To be determined

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

The Admitted Facts

12. At the outset of these proceedings, through her Counsel, Mr Mahmood, Dr Omar 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.

Witness Evidence

13. The Tribunal had before it witness statements from:

- Patient A, dated 14 April 2023, and a supplemental witness statement, dated 23 September 2024. Patient A did not provide oral evidence;
- Ms D, Dr Omar's former private medical secretary, dated 26 May 2023. Ms D did not provide oral evidence;
- Ms B, Quality and Risk Manager at The Sloane Hospital, dated 12 December 2023. Ms B provided oral evidence during proceedings;
- Ms E, Administrative Assistant for Medserv (providing medical secretarial services at the time of events), dated 23 September 2024. Ms E did not provide oral evidence;
- Ms F provided a witness statement on behalf of Dr Omar, dated 21 November 2024, with exhibits. Ms F also gave oral evidence.

14. Dr Omar provided a witness statement, dated 10 January 2025, with exhibits. She also provided oral evidence during proceedings.

Expert Evidence

15. The Tribunal received an expert report on behalf of the GMC from Mr C, Consultant Obstetrician and Gynaecologist, dated 23 March 2023. Mr C also provided two supplementary expert reports, dated 31 August 2023 and 23 September 2024. He also gave oral evidence.

Documentary Evidence

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

- Patient A's complaint to the GMC, dated 25 October 2022, with attachments;
- Patient A records held by Dr Omar provided to the GMC by email attachment, dated 8 November 2022, including email chain, various;
- Patient A records held by The Sloane Hospital received by the GMC by post on 11 November 2022, various;
- Records provided by Patient A to the GMC by email on 14 November 2022, various;
- Email from Circle health with attachments, dated 15 November 2022;
- Patient A records held by Elm House Surgery and Cator Medical Centre provided to the GMC on 19 December 2022 and 23 December 2022;
- Letters and emails between Dr Omar and the GMC, various;
- Telephone note of a discussion between Dr Omar and the GMC investigation officer, dated 11 January 2023

- Dr Omar's Rule 4 comments and Rule 7 response, dated 15 January 2023 and 28 March 2024, respectively;
- Emails between Dr Omar to Ms B, dated 6 June 2023;
- Emails between Ms B and the GMC, various;
- Testimonial evidence.

The Tribunal's Approach

17. 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 Omar 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. When considering the application of that standard, the Tribunal had regard to the case of *Byrne v General Medical Council [2021] EWHC 2237 (Admin) (10 August 2021)* which states:

> *'(1) There is only one civil standard of proof in all civil cases, and that is proof that the fact in issue more probably occurred than not.*
>
> *(2) There is no heightened civil standard of proof in particular classes of case. In particular, it is not correct that the more serious the nature of the allegation made, the higher the standard of proof required.*
>
> *(3) 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, it may take better evidence to persuade the judge that it has happened. This goes to the quality of evidence.*
>
> *(4) However it does not follow, as a rule of law, that the more serious the allegation, the less likely it is to have occurred. So whilst the court may take account of inherent probabilities, there is no logical or necessary connection between seriousness and probability. Thus, it is not the case that "the more serious the allegation the more cogent the evidence need to prove it".'*

18. On the advice of the LQC, the Tribunal also bore in mind the principle in the case of *Pope v General Dental Council [2015] EWHC 278 (Admin)* that if the Tribunal having weighed all the evidence in relation to an allegation considers the case evenly balanced, then the GMC will not have discharged its burden and will not have proved its case.

19. The Tribunal noted that it must reach its decision on the facts only on the evidence before it. It must not speculate but is entitled to draw reasonable inferences from what it has heard. When drawing inferences, the Tribunal must be able to safely exclude, as less than probable, any other possible explanations.

20. The Tribunal considered each paragraph of the Allegation separately in order to make individual findings. However, in relation to those paragraphs already admitted, or where another part of the Allegation was found proved, the Tribunal noted that, whilst it must consider any explanation or position put forward by Dr Omar, it may use those findings in making a decision on another allegation. However, it appreciated that such indication of propensity is only one relevant factor and is not a satisfactory substitute for direct evidence and the Tribunal must assess its significance in the light of all the other evidence in the case.

21. In considering the oral evidence the Tribunal has heard from the witnesses, the Tribunal noted that any attempt to assess a witness's credibility largely, if not exclusively, on that witness's demeanour when giving evidence was described by the High Court, in the case of *Dutta v The General Medical Council [2020] EWCA 1974 (Admin)*('Dutta'), as a 'discredited method of judicial decision-making'.

22. The Tribunal therefore sought to base factual findings on the inferences drawn from the documentary evidence and known or probable facts and use the oral evidence to subject the documentary records to critical scrutiny, and to consider the witnesses' personality and motivation. The Tribunal noted it should assess the evidence in the round and that witnesses' veracity should be tested by reference to the objective facts independent of their testimony, in particular by reference to the documents in the case.

23. This position is confirmed in the case of *Khan v General Medical Council [2021] EWHC 374 (Admin)* which also states that Tribunals should not assess a witness' credibility exclusively on their demeanour when giving evidence. The Tribunal should consider all of the evidence before them before coming to a conclusion about the witness' credibility. This could include conflicts in evidence with another witness, denials in the allegations and reasons why they could not be true. It is open to Tribunals not to rule out the whole of a witness' evidence based on credibility; credibility can be divisible.

24. The Tribunal took account of the fact that Dr Omar was of good character and the testimonials provided as they are relevant to the issue of her credibility and the likelihood of her acting or propensity to act in the manner alleged.

25. The Tribunal acknowledged the effect of the case of *Roomi v GMC [2009] EWHC 2188 (Admin)* which states that a Tribunal does not determine matters not forming part of the Allegation. Material being considered and weighed by way of context and background is relevant only in respect of deciding elements of the remaining parts of the allegation.

26. The Tribunal had regard to the relevant legal test for dishonesty as laid down by the Supreme Court in the case of *Ivey v Genting Casinos (UK) Limited [2017] UKSC 67*, which states:

> *"74. 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 the defendant must appreciate that what he has done is, by those standards, dishonest."*

27. Therefore, the Tribunal had to ascertain (subjectively) the actual state of Dr Omar's knowledge or genuinely held belief as to the facts at the material time. If this is established, the Tribunal would have to decide whether this was dishonest by the (objective) standards of ordinary decent people. If this is not established, then the Allegation would not be proved.

The Tribunal's Analysis of the Evidence and Findings

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

Paragraphs 3 and 4 of the Allegation

3. When you acted in the manner described at paragraph 2.a you knew that the entry you made was an incorrect record of fluid output during the Procedure.
   Determined and found not proved

4. When you acted in the manner described at paragraph 2.b you knew that you were providing inaccurate information to Patient A as to the extent of the fluid overload that developed during the Procedure. **Determined and found not proved**

29. The Tribunal noted that Dr Omar admitted paragraph 2a of the Allegation that, on a date or dates between 16 December 2020 and 6 April 2021 she retrospectively altered an entry in Patient A's medical records relating to the Procedure in that she overwrote the record of fluid output noted in the operation/treatment notes from '5.20' to '7.20L'. In examining the explanation she gave for the alterations, the Tribunal considered it appropriate to consider the two paragraphs together.

30. The Tribunal noted the background to the completion of the note and gave careful consideration in particular to the medical records of Patient A, the records and retrospective entries made by Dr Omar, her Rule 7 response, dated 28 March 2024, and her witness statement, dated 10 January 2025. It also was assisted by oral evidence given by the GMC expert, Mr C and Dr Omar's own oral evidence at the hearing.

31. The Tribunal noted the GMC's case. Mr Barton, on behalf of the GMC, contended that Dr Omar did not put forward an explanation for the retrospective entry until her admission at paragraph 2a which only came at a late stage, in her witness statement, 10 days before the hearing commenced. It was also the case of the GMC that Dr Omar previously strenuously denied the allegation in her Rule 7 response.

32. The Tribunal noted that Mr Barton further argued that Dr Omar had opportunities subsequent to the Procedure to indicate that her alteration to the operation note was retrospective. She could have included it in her Retrospective Entries as part of the Level 2 Incident Management Report ('Incident Management Report'), both dated 22 December 2020, some six days after the Procedure, or in her Rule 7 response letter. In addition, the GMC contended that Dr Omar had not sought any corroboration from her team who were a part of the Procedure to support her assertions.

33. The GMC's further suggestion was that given Patient A was clearly unhappy about her procedure and had asked for her medical records for a second opinion, Dr Omar was motivated, as suggested by Mr C, the GMC expert in his report, by *"professional embarrassment"* to alter the entry relating to the Procedure and did so at some time before providing the note to Patient A.

34. The Tribunal had regard to the witness statement of Patient A, dated 14 April 2023, where she stated:

> *"On 26 March 2021 I sent an email to Dr Omar's secretary [Ms P] and asked her for a copy of my medical records and any scans on file to be sent to me. The reason I made this request was because I was still in pain and wanted a second opinion. I received copies of my medical records on 6 April 2021 from Dr Omar's secretary…"*

35. Included amongst these records was the amended operation note.

36. The Tribunal considered that the GMC's case relied to a considerable degree on successfully challenging the credibility of Dr Omar's explanation in her statement as to why and when she altered the operation note. For the paragraphs of the Allegation to be found proven, the Tribunal recognised that it would have to be satisfied to the requisite standard that Dr Omar knew that her alteration was incorrect and that she was not being truthful about the amendment to the operation note. It noted the GMC argument that this was evidenced by the fact Dr Omar did not explain it in her subsequent accounts, only raised it for the first time in her witness statement, dated 10 January 2025, and that the alteration was only instigated by the patient complaining and was made just before she provided the operation note to Patient A.

37. The Tribunal examined the evidence relating to the operation note of 16 December 2020 and confirmed that on the copy of the note retained in the Sloane Hospital records, Dr Omar initially recorded that the fluid 'in' was 9 litres and fluid 'out' as 5.2 litres but the copy supplied to Patient A in April 2021 indicated fluid "out" at 7.2 litres. It noted that in her Retrospective Notes to the Incident Management Report on 22 December 2020, Dr Omar also recorded that the 'fluid out' was 5 litres.

38. The Tribunal considered Dr Omar's clinic letter, dated 20 December 2020, in which Dr Omar stated that, *"I decided to do a resection but she overloaded",* and made no further reference to it in that letter.

39. In noted also that in the rewritten letter, dated 16 December 2020, which is the subject of another allegation, Dr Omar stated:

> *"During the procedure, the pressure caused one of the bags to burst, and I was under the impression that I used a second bag of normal saline. The output was 5litres. However, after the operation, I realised it was a third pack, and pressure was put on 300mmg. The patient had 9 litres and the output was 5lites so there was a deficit of 4 litres…"*

40. In her witness statement, dated 10 January 2025, the Tribunal noted Dr Omar's account of what had gone wrong during the Procedure, which was subsequently confirmed in the Hospital Investigation:

> *"17. During the procedure I was told that the 3L fluid bag had burst and had been replaced by another one, and for that reason I was under impression that only 6L fluid was used. It was only after the procedure that I realised that three bags, totalling 9L, had been used.*
>
> *18. The ODP ['Operating Department Practitioner'] was outside the theatre when he walked in and realised there was blood in the tube of the canula in the hand of the*

patient, which he then pointed out to me. Nothing had been mentioned to me by the Anaesthetist, Dr [G]. I stopped the procedure immediately, at which point everyone was panicking, including the anaesthetist. Immediately I asked for frusemide, which is a diuretic, and placed a catheter. However, abruptly the anaesthetist took the tube out from her mouth and pushed the trolley with the patient to a recovery room, which is less convenient for monitoring. I asked the anaesthetist what he was doing, to which Dr [G] replied that he wanted to make a space in order to be able to send for the next patient. I told the anaesthetist to return the patient to theatre, and cancelled the rest of the list to concentrate fully on her welfare. During all this time there was fluid on the surgical drapes, on the patient and on the floor, which was not factored into the estimates of fluid used. The fluid amount was estimated solely by reference to the suction bottle, and therefore 5.2L output was recorded.

19. After Patient A had passed 2L litres(sic) of urine she felt much better, was talking and asking me to call her sister in addition to her mother. She is a small girl with a slim figure and any fluid overload could cause pulmonary oedema, which is why I believe the amount of deficit of fluid was exaggerated, although maybe I am mistaken on that. Following the patient's recovery, I reassessed the amount of fluid output during surgery to factor in the fluid that was on the drapes, the patient and the floor. I suggested to the theatre team that the 5.2L was probably an underestimation and that I would add 2L to account for this, to which the team agreed. By the time I went to amend the surgical note, however, the top sheet had already been taken and therefore the carbon copy was amended. I had no intention of in any way concealing or presenting a misleading picture, and made the amendment knowing that there was already another version in existence with the lower fluid output figure of 5.2L…"

41. The Tribunal then considered the written statement of Mr C, in which he referred to the operation note, in his supplementary report, dated 23 September 2024, he opined:

"The first was in the bundle supplied by the Sloane hospital and the second from Patient A. The difference is that the 'out' volume has been changed from 5.20 to 7.20l – resulting in a fluid deficit of around 2 litres as opposed to 4 litres.

The one that has been altered was the one that was in Miss Omar's possession (that she sent to the patient on or shortly after 31/03/2021) as the unaltered one was in the hospital bundle.

If it is established that Miss Omar altered the operation record, without explanation, then this would be considered seriously below the standard expected. This is unchanged from my original opinion."

And further:

"It is standard teaching that with resection procedures such as a transcervical resection of a fibroid, the fluid deficit is an important parameter to measure during surgery, as excessive fluid deficit can result in dangerous hyponatremia or pulmonary oedema. The patient was managed well following detection of the fluid overload. It was important to recognise the complication, and the absolute volume of overload is less important than the severity of its effects. Indeed, the handover letter to the receiving hospital, written by Dr [G], consultant anaesthetist makes no mention of the absolute volume of fluid overload.

Patient A suffered from significant fluid overload during the procedure on 16/12/2020, totalling around 4 litres. Standard practice would be to aim to limit this to one litre, and therefore an apparent fluid deficit of 2 litres is less professionally embarrassing than one of 4 litres. Altering the record after the event would have no outcome on the clinical outcome of the case. Many gynaecologists would consider that a 2 litre deficit is the absolute acceptable maximum for a hysteroscopic resection case."

42. The Tribunal then considered Mr C's oral evidence on the explanation for the amendment by Dr Omar which she maintained during her oral evidence. It noted that he largely accepted the plausibility of the account of the difficult and chaotic events after the occurrence of the fluid overload advanced by Dr Omar. He agreed that Dr Omar had been carrying out a tricky procedure, that complications arose leading to the fluid overload but acknowledged that all allegations about the clinical aspects had been resolved. He did not dispute that the lack of team communications concerning a 3-litre fluid bag which had burst during the operation would mean Dr Omar would have been under the assumption that 6 litres of fluid had been used when it turned out to be 9 litres. Mr C agreed that there appeared to have been a breakdown in communication and that could quite possibly have led to a miscalculation of fluid being used.

43. In relation to the scenario advanced by Dr Omar in her statement, the Tribunal noted Mr C initially expressed reservations about the circumstances in which the top copy was removed and Dr Omar could only make the correction in the fluid output on the carbon copy. He would not expect the copies to be separated until after the operation; the reason why there are two copies is one is filed within the hospital records, and the other one is for the surgeon's own record. He told the Tribunal that because the operating surgeon would often be an independent contractor to the hospital, and often there was a requirement for two sets of records, those notes tended to be separated on discharge rather than immediately at the end of the operation.

44. However it noted that he later accepted that the separation of the copies was entirely plausible indeed "*reasonable*" when it was put to him that Patient A was taken to an NHS based hospital within minutes rather than hours after the Procedure. He said that one copy of

the operation notes would either be photocopied or one of the copies sent with the patient because it was very important to make sure that the receiving hospital knows exactly what has happened. He said that in picking up a case in the middle of something, particularly where there has been a complication, it was very important to make sure that there was good communication from one institution to another. He said *"yes, absolutely. I think it would be good practice to make sure that one copy of Operation Note goes with the patient".*

45. Mr C further accepted without demur that there was nothing wrong in a surgeon re-estimating the amount of fluid output after the procedure has settled as it was important to make sure that what is written on the notes is accurate whilst indicating the importance of changing both copies or making a note to that effect. He said that otherwise there would be a situation in which one copy is incorrect and one copy that is correct. It was important to the Patient's management that a message got through to say what the actual estimate was and this should have been communicated to the next hospital. He conceded that Dr Omar was in a very difficult situation, there was an emergency, and in modern medicine there is a reliance on the team around you. He said that whilst the ultimate responsibility may lie with the consultant, there were certainly a lot of mitigating factors. The Tribunal noted his criticism was that Dr Omar did not annotate the carbon copy with an explanation for the amendment, and that she did not also make the same change to the top copy.

46. Mr C also made the point that how much fluid a patient might be overloaded by was an important piece of information which was very salient to their immediate management and there was a responsibility to make sure the correct information goes with the patient if the top copy was not there because it had been taken away with the patient. Mr C said that if you knew that the fluid deficit was 4 litres and not 2 litres, then that might be managed in a different way and a different threshold of treatment might be used.

47. The Tribunal noted Mr C addressed, in his oral evidence, the possible motive that he had advanced in his report for Dr Omar's altering of the operation record. He expanded by emphasising that, if the record was altered afterwards and not communicated, then that would have no bearing on the clinical outcome on the way this situation played out. However, a deficit of 4 litres as opposed to 2 litres suggests something quite significant has gone wrong in communication within the theatre. It is entirely understandable one can lose one's focus on other issues when concentrating on a very difficult case, but a fluid deficit of 4 litres should have been obvious to the Team. He said it was not for him to establish the intent behind the change.

48. The Tribunal considered that Mr C's evidence was measured, that he was very knowledgeable of Dr Omar's practice as he was actually working as a consultant gynaecologist and obstetrician, and he made concessions in areas which were not directly in his knowledge, such as practices and policies within a different private hospital group. He had a clear

understanding from his expertise of the difficult and chaotic situation faced by Dr Omar during the Procedure.

49. The Tribunal considered that the focus of his (Mr C's) criticism in his report had been that Dr Omar made the alteration without an explanation. Now that Mr C had been able to deal with the appropriateness of this in his oral evidence, it noted that had no issue with the fact that Dr Omar went back straight after the Procedure once the Patient was in recovery and re-assessed the fluid output. It noted Mr C agreed that Dr Omar's account was plausible, given the circumstances.

50. He was also of the view that whilst unusual, the manner in which Dr Omar's case is put regarding how the top copy of the operation note was removed was not implausible. The Tribunal was clear that he was of the view that Dr Omar should have annotated the operation note and made efforts to add the same re-assessment/annotation to the top copy if the notes were separated. However, it noted that given the circumstances, the focus would have been on the clinical condition of the patient.

51. The Tribunal considered that Mr C's evidence did not undermine Dr Omar's explanation for the alteration.

52. The Tribunal then considered whether the account put to Mr C was in effect, as the GMC alleged, recent invention. It considered Dr Omar's Rule 7 response, in which she stated:

> *"The operation/treatment note … in which Dr. Omar has recorded fluid input of 9 litres, and fluid output of 7.2 litres. The amount 7.2L was based on a combination of fluid output, urine output and included the diuretic. However, the estimate did not factor in the quantity of fluid on the surgical drapes on the theatre floor, which likely explains the discrepancy of 1.8 litres.*
>
> *It is not clear as to on what basis it is alleged that Dr. Omar amended the operation note retrospectively, or what the evidence for this assertion is, although in any event this is strenuously denied."*

53. The Tribunal reminded itself that it was the GMC's case that on the one hand, Dr Omar *'strenuously denied'* the allegation in her Rule 7 response, but now admitted that she made the alteration in her witness statement, dated 10 days before the start of these proceedings. The Tribunal was of the view however, that there was some ambiguity in the way in which this response was interpreted by the GMC. It considered that when both paragraphs were read together, as opposed to just the second paragraph, the Tribunal understood Dr Omar to be strenuously denying dishonesty, as the first paragraph refers to the factors upon which her case is based in regards to making the alterations to the operation note; "*The amount 7.2L was based on a combination of fluid output, urine output and*

included the diuretic. However, the estimate did not factor in the quantity of fluid on the surgical drapes on the theatre floor, which likely explains the discrepancy of 1.8 litres."

54. The Tribunal noted that she had in fact referred to these details earlier in that statement as follows:

> *"During all this time there was fluid on the surgical drapes and on the floor, which was not factored into the estimates of fluid used. The fluid amount as subsequently recorded in the operative note was estimated solely by reference to the suction bottle."*

55. The Tribunal considered this provided further support that re-estimation of the fluid level was not a recent invention.

56. It recalled that Mr C told the Tribunal that for Dr Omar to go back and re-assess the quantity of fluid on the drapes, bucket and splashes on the floor was acceptable and a plausible explanation.

57. The Tribunal also recalled the GMC's contention that the alteration to the operation note was a lie and this was borne out as it was not recorded anywhere else, and that it was only done just before Dr Omar had to send a copy to Patient A, and Mr C had put forward the potential motivation for this as *"professional embarrassment"*, as previously set out. He did accept in oral evidence however that the top copy may have been incorrect and as a professional, you do re-assess, the main criticism being that she did not annotate the record to reflect that, or the top copy.

58. The Tribunal considered the oral evidence of Dr Omar who was examined thoroughly on the GMC's case. It noted that she sought to meet the GMC's contention that she had not told the GMC earlier about the altered operation note by indicating that she had addressed the matter with the GMC investigator, Ms H, but that when she had something in her mind it did not always come out as if she were writing it. The Tribunal noted that within what was recorded on the telephone note there was no mention of a discussion about the fluid overload or the alteration to the operation note.

59. The Tribunal was mindful that the telephone note provided a gist of the conversation and was not a verbatim account; it neither supported nor undermined the account of Dr Omar in this regard. Indeed it was not clear to the Tribunal whether at that point in the GMC investigation, the alteration to the operation note was a 'live' concern for the GMC, and if so whether that was even on Dr Omar's radar. It noted that Mr C's supplemental report in which this matter was addressed, was produced in February 2024, and the telephone note was from a call in January 2023. Dr Omar maintained however that she told Ms H everything about the Procedure. The Tribunal was not assisted either way with evidence on this telephone conversation.

60. The Tribunal noted Mr Barton did not challenge to any degree Dr Omar on the fluid deficit level or suggest that her account of the circumstances surrounding the altered amount was a lie or that the fluid deficit level was wrong and noted again that Mr C, had in his oral evidence, accepted her explanation as plausible, if not unusual. He did however challenge Dr Omar about the events after Patient A was safe when presumably there was a time where she and her team were able to communicate to work out what had gone wrong. Dr Omar was consistent in the details of the situation she had described in her statements and which had been put to Mr C in cross examination. Her reaction to the fluid overload was horror, devastation and shock as this was the first time this had happened to one of her patients. She said her first thought was for the well-being of the patient and her treatment. She said that everyone was panicking but as team lead she had to think quickly, advise the team, put on a brave face and work for the well-being of the patient. She confirmed the patient was moved to recovery and she had to write the quick operative note and checked the fluid input and output with the output measured from the suction bottle.

61. Her account that there was no discussion time with the team, that it was chaotic, that she was only thinking how to treat the patient appeared convincing to the Tribunal particularly based on Mr C's evidence. She repeated her written account of how the operation note went with the patient to the recovery area and thereafter she had a discussion with her team. It was Dr Omar's account that it was agreed by her and her team that the fluid output figure was more likely to be 7.2 litres, that they had underestimated this and all agreed that it should be changed, and that it was at this point she realised the top copy of the operative note was missing. She said that following that chaotic and difficult situation, it did not enter her mind to go back to the to the original copy and change the original copy as it would make no difference in respect of the condition of the patient. She told the Tribunal the copy of the operation note she altered was the only copy which existed with her and which she scanned and uploaded to her secretary to put in the patient record the same day.

62. The Tribunal noted her response to questions put to her to the effect that if it did not matter about the actual amount of fluid, why did she feel the need to change one of the records. Dr Omar said that she would have liked to have changed both copies of the operation note but the original was not there. She said she wanted to make the change to estimate the exact amount of fluid but she considered that the pressure on the machine which was double what was normal and was a significant contributory factor. She stressed there was no motive or dishonesty in the reason for changing the operative note, only that she wanted to know the exact amount of fluid in and out and to know how this patient was going to be affected given that she was an experienced surgeon and knew what impact this could have.

63. Dr Omar also accounted for why she had not spoken to any of her team to be witnesses when she realised the GMC were making allegations that she had acted

dishonestly. The Tribunal found the reasons substantive and understandable. As to whether in the course of the hospital investigation she told the Sloane Hospital that their record was wrong, she accepted she did not, as the levels made no difference to the investigation. However, she had taken full responsibility of the situation and acknowledged that she should have communicated better.

64. Dr Omar also accepted that when she made her Retrospective Entry to the medical record, on 22 December 2020, 6 days after the Procedure, that was an opportunity to clarify the position as to the correct amount of fluid deficit but it did not cross her mind.

65. The Tribunal noted Dr Omar's explanation why, when she came to prepare the "rewritten" letters when Ms B provided her with Patient A's file from the Sloane Hospital records, she repeated the deficit of 4 litres but did not correct the figure. It considered it understandable with the stress she was under that she would have depended on what was in the record from Sloane Hospital. It accepted that her focus was on providing any information to the GMC to help the investigation, and understood her reluctance at that stage to change anything in the original record at the Sloane Hospital.

66. The Tribunal noted again that this was the first time she had been the subject of a complaint to the GMC and she had no legal representation or advice at this juncture.

67. The Tribunal examined Dr Omar's case that following the Procedure, she was professionally rethinking and assessing the fluid outcome and her account of why only the one copy had been amended and the original figure on the top copy had not subsequently been altered. It considered it significant that she said that it did not enter her head that she had to defend herself for re-assessing the fluid deficit, as whether it was 1 litre or 4 litres, the fluid overload was still the cause of the pulmonary oedema. This was a situation that she took responsibility for and for which she was cleared of fault in a subsequent internal investigation.

68. The Tribunal noted and accepted Dr Omar's account that she did not use paper copies of the records all the time and that there was no need to keep operation notes in the medical records as they were scanned by her and sent to her secretary for uploading to the Medical Practice Management system. This seemed consistent with the document records before the Tribunal. The Tribunal considered this would have made it less likely she would have altered the record later when Patient A asked for her records. It also noted, and accepted, that there would have been chaos at the time of the Procedure when the complications happened and that the focus would have been on Patient A and her recovery, even though Dr Omar's immediate surgical involvement had finished, she was still concerned for the patient. The Tribunal accepted that whilst Dr Omar could turn her attention to the fluid output re-assessment, she did not make any attempt to find the top copy or ask others to make enquiries to do so. It also accepted that the stress and panic would have played a role.

69. The Tribunal was of the view that it was entirely plausible that Dr Omar's focus was on the patient and resolving the differences in the two copies of the operation note had slipped her mind. It was concerned that in Dr Omar's retrospective entry on 22 December 2020, she again referred to 9 litres of fluid input and 5 litres of output and did not take the opportunity to replicate her correction to the operation note and provide her reasoning. It considered her explanation that she knew the fluid overload made no difference to the outcome and had already accepted responsibility for this. However, the Tribunal found this explanation less convincing than her rationale for making the original change to the operation note.

70. It was also Dr Omar's case that she was absolutely fine for another consultant to take a look at the records for a second opinion and she was not trying to hide anything, rather she was trying to be accurate. Both Dr Omar and Mr C said that were was no benefit in changing the fluid deficit because anything over 1 litre would have been enough to cause pulmonary oedema.

71. The Tribunal examined again the GMC's expert's suggestion that *"professional embarrassment"* may have been a motivation for her action which appeared to have been a factor behind the laying of this allegation. It noted Mr C's concession that he did not know what Dr Omar's motivation was, or what was in her mind and that Dr Omar's motivation was not a matter for him, that it was a matter for the Tribunal. The evidence on this contention seemed limited as those medical notes were already in existence at another hospital as were her account in the Retrospective Notes to the investigation. She had taken responsibility for the overload and made no attempt to cover up that situation in any subsequent correspondence or notes. For these same reasons, the Tribunal rejected the assertion that Dr Omar's intent was to cover up or deceive anyone with the altered fluid deficit.

72. The Tribunal also noted that Mr C agreed that Dr Omar was entitled to re-assess the fluid output amount after the Procedure. In addition, there appeared to have been a breakdown in communication between Dr Omar and her team in the difficult circumstances.

73. In respect of Dr Omar not providing an explanation early on for the alteration to the operation note, the Tribunal was satisfied that this was not one of the earlier allegations put to her that she had to answer. Further, it recognised that Dr Omar had no legal representation until August 2023.

74. The Tribunal noted that Mr C accepted that overall, the emergency was well handled and there were no questions regarding Dr Omar's competence, which, in the Tribunal's view, reduced a likely motivation to cover up or some other ulterior motive for the alteration.

75. The Tribunal considered Dr Omar's credibility in respect of her evidence and the consistency of her accounts. It noted that her written and oral evidence in respect of these allegations concerning the alteration to the operation note was largely consistent and not

significantly weakened during detailed and thorough examination by the GMC. Where there were some variations, it accepted that Dr Omar had occasional difficulty in expressing herself in what was not her first language. It further took into account that the criticism expressed by the GMC expert in his report of the lack of explanation for the alteration, had been thoroughly explored in his oral evidence. It noted that he had largely accepted the plausibility of the rationale for the change while reserving his criticism for a failure to ensure accuracy across both copies of the operation note.

76. The Tribunal acknowledged the GMC's proper concession that Dr Omar was of good character. It had regard to the many statements testifying to Dr Omar's integrity and honesty. In addition, when considering Dr Omar's credibility, integrity and good character, it had regard to the testimonial evidence before it:

Dr I, Consultant Anaesthetist and Intensivist, dated 1 March 2024:

> *"…She is honest and trustworthy and I have no concerns about her integrity or probity"*

Miss J, Consultant Obstetrician & Gynaecologist, 4 March 2024:

> *"…Over the ten years that I have worked closely with Miss Omar, not once have I had any doubts or concerns with regards to her integrity, or honesty, and I have only ever been impressed and inspired by her clinical knowledge, ability and professionalism."*

Ms K, Clinical Services Manager – Theatre, dated 4 March 2024:

> *"Honesty and Integrity:- During the last 12 months of knowing Dr Kazal Omar, I never had any reason to question her honesty or integrity. I find Dr Kazal Omar's approach is very professional and caring."*

77. The Tribunal found it significant that testimonials came from Dr Omar's peer group as well as those who support her in an administration role.

78. Again the Tribunal reminded itself that throughout the investigative process, Dr Omar took full responsibility for her actions and did not seek to blame others which militated against a motive to conceal failings.

79. The Tribunal determined that given Dr Omar's good character and having had regard to all the documentary and oral evidence, it was satisfied that Dr Omar's accounts were credible. Where there remained some inconsistencies, the Tribunal gave Dr Omar the benefit of the doubt given her overall credibility. Taking all the above into account and reminding itself of Mr C's concessions in respect of Dr Omar's rationale for altering the record at the time she did, the Tribunal concluded that the GMC have not proven on the balance of probabilities that Dr Omar knew it was an incorrect record.

80. The Tribunal therefore determined that when Dr Omar retrospectively altered an entry in Patient A's medical records relating to the Procedure in that she overwrote the record of fluid output noted in the operation/treatment notes from '5.20' to '7.20L'; on a date or dates between 16 December 2020 and 06 April 2021, the GMC have not proven that she knew that the entry she made was an incorrect record of fluid output during the Procedure. It further determined that as a consequence, the GMC have not proven to the requisite standard that Dr Omar knew that she was providing inaccurate information to Patient A as to the extent of the fluid overload that developed during the Procedure.

81. The Tribunal therefore found paragraphs 3 and 4 of the Allegation not proved.

Paragraphs 5a and b of the Allegation

5. Your actions at paragraphs:

   a. 2.a were dishonest by reason of paragraph 3;
   Determined and found not proved

   b. 2.b were dishonest by reason of paragraph 4.
   Determined and found not proved

82. The Tribunal was of the view that if Dr Omar did not know something to be inaccurate, then she could not be dishonest within the terms of the Ivey case. The Tribunal determined therefore that given its findings in respect of paragraphs 3 and 4 as already set out, paragraphs 5a and b are not proven.

83. The Tribunal therefore found that paragraphs 5a and b of the Allegation not proved.

Paragraph 7bii of the Allegation

7. When you acted in the manner outlined at paragraphs 6.a-6.c, you:

   b. knew that:

      ii. the date upon which the letters were actually written was not made clear;
      Determined and found not proved

84. The Tribunal noted that Dr Omar admitted paragraphs 6a-c of the Allegation, namely that between a date on or around 22 December 2020 and 8 November 2022 she; a) rewrote a letter in retrospect dated 11 November 2020 regarding Patient A which was readdressed to Beckenham Beacon; b) rewrote a letter in retrospect dated 16 December 2020 regarding Patient A which was readdressed to Beckenham Beacon; and, c) rewrote a letter in retrospect dated 31 March 2021 regarding Patient A which was readdressed to Beckenham Beacon.

85. The GMC's case was based on the construction of three letters and them being addressed to Beckenham Beacon by Dr Omar and that they were then passed off as fake records. Dr Omar admitted that she re-wrote the letters. The GMC also averred that Dr Omar was inconsistent in her accounts in relation to difficulties accessing her records and the circumstances surrounding the re-writing of the letters.

86. This allegation stems from an investigation undertaken by the GMC on 25 October 2022. The Tribunal was taken to correspondence about the investigation in which Dr Omar was requested to provide the medical records she had for Patient A.

87. The Tribunal noted that the GMC not only requested documents from Dr Omar, but also requested and received the medical records of Patient A, from Patient A. The records were requested by Ms H in an email to Dr Omar on 15 November 2022 and that Patient A's copy of her medical records were sent to the GMC on 14 December 2022. It was as a result of this disclosure by both Dr Omar and Patient A that the anomalies in the letters, as set out at paragraph 6 of the Allegation were discovered. Many of those anomalies were admitted by Dr Omar in that she admitted that she rewrote 3 clinic letters, dated 11 November 2020, 16 December 2020 and 31 March 2021 and had sent them to the GMC.

88. In his expert report, Mr C stated:

> *"There are two versions of two letters from Dr Omar to Patient A 's GP– dated 11/11/2020 and 16/12/2020. The two relating to 11/11 are similar, however the ones from 16/12 contain significant differences…*
>
> *Both letters were dated 16/12/2020. The first appears to have been taken from a bundle supplied to Patient A and thus is likely to have been written contemporaneously.*
>
> *The second letter refers to ongoing care at an NHS hospital, and an echo which was performed post operatively. (22/12/2020 …) Therefore, this letter, dated 16/12/2020, cannot have been written contemporaneously.*
>
> *There is an email from Dr Omar explaining the different versions of letters…*
>
> *…The content of the letter is materially different to the 'original' letter… At the very least, I would expect that a rewritten letter would contain the date on which it was written, and an explanation for why there is a new letter in the records (even if, for example, said explanation was that the original had been deleted).*
>
> *… If it is shown that Dr Omar rewrote the clinic letters without explanation or clarification, then this is also seriously below the standard expected. This falls seriously below the standard expected as patient safety and efficient handover of care is*

dependent on accurate communication between health professionals, and thus to materially alter the content of correspondence is unacceptable in clinical practice."

89. It was the GMC's case that Dr Omar's actions were not only seriously below the standard but also dishonest.

90. From the written evidence, Dr Omar's case appeared to be that she did not disagree with much of Mr C's opinion, albeit she denied that she knew the date upon which the letters were actually written or that she checked and/or knew the GP address of the letters were incorrect.

91. The GMC Investigation Officer, Ms H, put the concerns raised to Dr Omar in an email, dated 15 November 2022, in which she stated:

"I'm emailing in relation to our Provisional Enquiry of the concerns raised by Patient A

I have now received patient records from The Sloane Hospital; the four clinic letters provided by yourself and additional records from Patient A who has advised that the records were sent to her by your Secretary.

I've reviewed the records that Patient A has provided. Patient A has shared the following records which do not appear to be in the bundle of records from yourself or The Sloane Hospital:

- *Consultation Notes dated 2 July 2020*
- *A clinic letter of 11 November 2020 containing details regarding the ultrasound of the pelvis/T/V ultrasound*
- *A clinic letter to Trinity Medical Centre dated 11 November 2020*
- *Blood report dated 16 December 2020*
- *A clinic letter to Trinity Medical Centre dated 16 December 2020*
- *A histology report dated 21 December 2020*
- *An Echocardiogram report dated 22 December 2020*
- *A clinic letter to Trinity Medical Centre dated 13 January 2021*
- *Consultation notes dated 24 March 2021*
- *A clinic letter of 24 March 2021 containing details regarding the ultrasound of the pelvis/T/V ultrasound*
- *Page 1 and Page 3 of the patient's scan photos*

I'm also aware that the patient underwent a chest x-ray on 16 December and the radiologist's report does not appear to be included in the records from yourself or the records from The Sloane Hospital.

I'd be really grateful If you could please confirm whether the above records are held by yourself/your secretary or The Sloane Hospital?

Please could you also double check that you don't hold any additional records for the patient (other than the 4 clinic letters that you have previously shared with me)? If you do hold copies of additional records, please could you send these to me?

It's really important for us to ensure that we have copies of all available records and to ensure that there are no missing records."

92. In the GMC's Assistant Registrar's Decision Reasoning to proceed with an investigation, dated 9 January 2023, which was annexed to the GMC decision letter, dated 10 January 2023, it was stated:

"The expert noted that Patient A had been sent copies of her medical records from Dr Omar's secretary. These medical records contained clinic letters sent from Dr Omar to Trinity Medical Centre dated 11 November 2020, 16 December 2020 and 14 January 2021. The letter dated 11 November 2020 states that Trinity Medical Centre had referred Patient A to Dr Omar. The expert advised that Dr Omar had provided a copy of three clinic letters addressed to Beckenham Beacon, dated 11 November 2020, 16 December 2020 and 31 March 2021. The letter dated 11 November 2020 states that Beckenham Beacon had referred Patient A to Dr Omar."

93. The Tribunal went on to consider whether Dr Omar's various subsequent accounts as to the circumstances in which the letters came to be constructed, were consistent. Dr Omar telephoned Ms H on 11 January 2023 and a telephone note was made of the call:

"Dr Omar called in relation to the correspondence that I had sent to her the previous day (confirming that the PE had been promoted to an Investigation).

She asked if she could provide her own comments on why the letters were different. I confirmed that Dr Omar could provide anything she wanted us to take into consideration including her own comments, and that this is something we would consider. I re-iterated that we had decided that we needed to look into the matter further, and that at this stage no findings had been made.

Dr Omar explained that this matter was a mistake and that she had not forged the letters. She confirmed that she never changes her notes.

Dr Omar advised that her secretary had resigned in 24 hours on 24 February 2021 due to family issues and that she believed the secretary had put all of the information onto a disk. She was under the impression that all of her notes were on the computer system.

Dr Omar explained that a lot of information was missing, so she went back into the notes at Sloane Hospital in front of a manager and re-wrote the letter, as the original letter had been given to to the patient herself, along with the imaging.

She noted that the secretary had tried to contact the GP but that it seems they had contacted the wrong GP.

Dr Omar reiterated that there had been no fraud.

Dr Omar advised that she read my correspondence after working in theatre and that she had [XXX] *from the shock of it. I acknowledged that I could appreciate my correspondence had been worrying and I apologised if this had caused her any upset. I acknowledged that this must be a very stressful situation for her to be in. She confirmed that she had never been involved with the GMC and that it was stressful.*

I reassured her that if she did send any comments via email, then I would forward these over to our Investigations team as soon as possible."

94. The Tribunal noted that a telephone note was not a verbatim account of everything that was said. It was also Dr Omar's evidence that the telephone call lasted about 20 minutes and that she explained everything that had happened in respect of the Procedure and in respect of Patient A.

95. On 15 January 2023, Dr Omar emailed Ms H, in which she stated:

"…I also notify my legal advisor about the letters as they are rewrite ,it was because my secretary resigned in early 2021within 24 hour notice ,she handed over 2 USB disc as she thought all my patient information's are saved on. and wiped out all my patient information's on the computer.

I have now a secretary with medical practice management software when they tried to upload all information from USB disc but they found out a lot of them are missing. Including Patient A note. I did ask my secretary to retrieve the letters from her GP but it is obvious she contacted a wrong one whom they had nothing related to my care for her.

I asked the risk manager at The Sloane hospital for copy of the note and informed her with the reason.

Infront of her I dictated the letters again according to my hand writing note and remembering her case, for that reason there are some difference and my secretary put the wrong GP practice name
I never have intention to deceive or make up any thing to look good and I am fully aware you and the patient have all of original note.

I must admit this is a mistake and I should said from the 1st time I don't have any record for the reasons I mentioned above."

96. Dr Omar also prepared a document, dated 14 May 2023, in which she provided to the GMC, in which she stated:

"…I wrote two separate letters detailing the procedure and incident. There was question as to why two letters exist. The details are as follows:

- *The first letter was dictated very soon after the incident. This was a letter that was sent to the patient's GP explaining that the complication occurred and was managed in hospital in December 2020. In February 2021 my secretary resigned and for data protection reasons deleted all patient data from her computer. After being notified of the complaint I tried to obtain a copy of the letter sent in November 2020. I felt it was sensible to seek help from the risk manager. She was able to locate the patient's medical records. Based on the medical records I dictated a retrospective summary intended to specifically address the complaint. This occurred in the presence of the risk manager. The medical records of this patient have never been altered.*
- *The second letter was more informative and based on medical notes and memory. The operative date was stated on the letter and overlooked by mistake – it was not intended to imply the letter was dictated on the 16/12/20 as that would be impossible due to that being the operative date. I however, do realise the operative date is stated under the heading 'GP/REFERRAL letter'. It does also state 'Completed ... Medical Secretary 8 November 2022 08:09' and the theatre admission date is stated. The intention was not malicious or fraudulent. This can be evidenced by the fact the dictation of the summary was in the presence of a risk manager, is retrospective and the first letter has never been tampered with and exists. Furthermore it does not include parts e.g. consent details relating to fluid overload that could be seen as attempting to reduce my responsibility. I did not have any intention to mask the first letter - both letters have been received by the*

GMC. The summary was dictated to detail the incident for the purpose of the GMC complaint…"

97. The Tribunal noted that Dr Omar confirmed in her oral evidence that a close family member helped her produce this letter to ensure that she was able to get her account on paper clearly as she had no legal representation at that time.

98. Dr Omar also provided accounts as to the difficulties that arose at the time in respect of technical issues in obtaining the medical records from the Medical Practice Management system, and also with her secretarial staff.

99. Dr Omar expanded on the issues she was having in relation to the Medical Practice Management system she was using in her Rule 7 response, which she subsequently switched provider:

"On 23 February 2021, Dr. Omar's medical secretary for her private practice, [Ms D], resigned with only 24 hours' notice due to family reasons. At the point of her departure, Ms [D] gave to Dr. Omar USB sticks containing all the private patient data she held, which Ms [D] appropriately had deleted from her computer. Ms [D] has provided a witness statement to the GMC, dated 26 May 2023…

Following her secretary's sudden departure, Dr. Omar decided out of necessity to subscribe to Medserv Practice Manager for administrative support in respect of her private practice.

Dr. Omar was with Medserv from March 2021 until May 2021. Dr. Omar's secretary informed her that all private patient data had been sent to Medserv to upload onto their Cloud platform. Dr. Omar paid Medserv for uploading the data, who in turn confirmed to Dr. Omar that the patient data had been uploaded. Dr. Omar reviewed a selection of patients over a few years and months, and everything appeared to be present on the Medserv system. As Dr. Omar then felt she would no longer need to retain paper patient folders, at some point after March 2021 Dr. Omar shredded all private patient records in her possession.

Dr. Omar's last consultation with Patient A was on 31 March 2021. During this consultation Patient A asked Dr. Omar to provide her with a copy of her records. At that point in time, Dr. Omar still had Patient A's original private records, which Dr. Omar arranged to be sent to Patient A by recorded delivery. It at was at some stage time after providing Patient A with her own records, and after having completed the

digital transfer of her records to Medserv, that Dr. Omar shredded her own paper records.

After only a few weeks, Dr. Omar found Medserv to be prohibitively expensive, and at the same time to lack continuity with secretarial support. As a result, Dr. Omar began looking for a replacement secretary, who is Dr. Omar's current secretary, [Ms F]. With the assistance of Ms [F], Dr. Omar also identified an alternative digital provider, Medesk Practice Manager, which was a much better match for Dr. Omar's practice. Dr. Omar asked Medesk to arrange for the digital transfer of all her private patient records from Medserv to Medesk. The Medesk Manager told Dr. Omar that he would arrange for his IT team to upload the data without charge, even though Dr. Omar would have been happy to pay this again. Dr. Omar was then under the impression that all the folders had been transferred securely.

Medserv removed Dr. Omar's access to their practice desk after closing Dr. Omar's account. Unfortunately, between May 2021 and up to the time of Patient A's complaint to the GMC, Dr. Omar had had no reason to review any of her previous patients' notes..."

100. The Tribunal then had regard to her witness statement, dated 10 January 2025, in which Dr Omar stated:

"23. Following my secretary's sudden departure, out of a degree of desperation I decided to subscribe to Medserv Practice Manager for secretarial support and invoicing in respect of my private practice. I have been undertaking private work alongside my NHS practice since 2007.

24. I was with Medserv from March 2021 to May 2021. My secretary told me that she had sent all the data from my private work to Medserv to download onto their Cloud system. I paid Medserv for uploading the data, and they reassured me that they had uploaded the information. I checked a selection of patients over a few years and months, and everything appeared to be there. As I felt I would no longer need to retain paper patient folders, at some point after registering with Medserv, for data protection reasons I shredded all the notes I held up to that time.

25. I should mention at this point that my last consultation with Patient A was on 31 March 2021. During this consultation Patient A asked me to provide her with a copy of her records, which I arranged to be sent to Patient A by recorded delivery. For reasons explained below, it must have been at some time after providing with her own records that I shredded my paper records.

26. After approximately 2 months I found Medserv to be very expensive and also difficult to use, as they allocated a different secretary every day which caused my patients to complain about lack of continuity. I began looking for a replacement secretary, who is my current one, [Ms F]. With the assistance of [Ms F], I found an alternative provider, Medesk Practice Manager, which was a much better match for my practice. I asked Medesk to arrange for the digital transfer of all my patient records from Medserv to Medesk. The Medesk Manager promised me that he would instruct his IT team to do that without charge, even though I would have been happy to pay this again. I was then under the impression that all the folders had been transferred securely.

27. Medserv had blocked my access to their practice desk after I left them. Unfortunately, between May 2021 and up to the time this lady complained to GMC, I had no reason to review any of my previous patients' notes."

101. The Tribunal considered that overall, Dr Omar's accounts of the difficulties she had with the Medical Practice Management system and Ms D's departure after she thought patient medical records were saved to a USB stick/disc before she resigned giving 24 hours' notice, were consistent; in the telephone note, the Rule 7 letter and the witness statement. Dr Omar's contention was that she was under the impression that patient medical records were on the Medserv system and had been transferred to Medesk.

102. The Tribunal observed that it was more understandable that by this time, from August 2023, when Dr Omar had sought, and obtained legal advice, and the full circumstances of her account for the investigation could be explored in more detail, without it in any way implying invention or dishonesty. The Tribunal considered that it may not have been fully apparent to Dr Omar the importance of this background and why she might have needed to provide all this detail. In any event, the GMC's own witness, Ms D, provided a witness statement confirming that, *"On my last day working with Dr Omar, I transferred all the clinic letters that were saved on my laptop onto a USB drive and handed this over to Dr Omar… I knew due to data protection that I was no longer entitled to keep this information. Once the clinic letters had been transferred onto the USB drive, I deleted them from my laptop"*.

103. The Tribunal noted however, that as Ms D did not attend these proceedings, it has not been possible to test with her Dr Omar's account that Ms D may not have saved all the patient data on the USB stick /disc nor have the GMC been able to rebut Dr Omar's repeated and consistent position on this. All the statements before the Tribunal appeared however to confirm that there was some moving of records from one system to another and that that event occurred just before the Patient A's medical records were sent to Patient A. It noted that paper copies of Patient A's medical records were sent to her via recorded delivery and they were also sent via email on 6 April 2021.

104. It was only sometime later, when Dr Omar needed to access Patient A's medical records, following the request by the GMC for the records in November 2022 when, Dr Omar discovered that they were not there. It was Dr Omar's account that by this time she did not keep paper copies of medical letters, that they would be kept electronically, and that operation notes would be photocopied, or a picture taken on her phone and that would be sent to her secretary for uploading and the paper copy shredded. It was Dr Omar's account that she was unable to retrieve the email with the medical records attached which was sent to Patient A on 6 April 2021, as that email address belonged to Medserv and once she switched to Medesk, her current secretary, Ms F could not retrieve that email.

105. On 6 April 2021, the Tribunal noted that Dr Omar's then secretary, 'Ms E', email Patient A her medical records. In her email to Patient A she stated that, *"Miss Omar wanted to me to email your reports and clinic letters to you, just in case the post has been delayed…".* This email suggested that, at that time, there were both paper and electronic copies of Patient A's medical notes available. The evidence before the Tribunal was that all Dr Omar's patient records had been uploaded to a USB stick for them to have been uploaded to Medserv, that Patient A's medical records were also uploaded to Medserv at that time, and therefore the Tribunal accepted Dr Omar's account that she was satisfied she could shred the paper copies.

106. This account was supported by the record of the telephone note on 11 January 2023 in which it stated that Dr Omar believed the secretary had put all of the information onto *'a disk'* and was under the impression that all of her notes were on the computer system.

107. In her oral evidence, Dr Omar said that nearly every week a patient wants their record either for second opinion or for family member to see the record. She said that this was very usual for a patient to ask for their record. She rejected the suggestion by Mr Barton that this meant she knew her records would be coming under scrutiny and said that patients have a right to take their records as they belong to them. Dr Omar said that it was fine if Patient A wanted a second opinion and her records were scrutinised by another consultant, that there was nothing to be afraid of.

108. Dr Omar told the Tribunal that she signed up to Medserv at the end of February (2021) and that she also had paper records between end of February and middle of April (2021), but that the paper record was no longer of any relevance to her and that was why in the middle of April she shredded the paper copies. She said that she sent copies of the letters to Patient A but that the copies of the operation note, which were uploaded on 16 December 2020, and the photos of the operation note, was uploaded on to the system, were not a part of her paper copies.

109. Dr Omar's oral evidence on the transition from Medserv to Medesk, and the problems of record retrieval, did not vary from her previous written account. She confirmed that she

tried everything to get the records for the GMC including asking Ms F to contact the GP. The Tribunal noted GMC questions to the effect it was her responsibility to ensure a copy of her medical notes go to the Sloane Hospital and Dr Omar's concession on that. However, the Tribunal reminded itself that it should confine itself to the matters before it and not consider issues which did not form any allegations.

110. The Tribunal noted that Patient A did receive her medical notes and that they were sent in good faith by Dr Omar as she said in her oral evidence, she did not have anything to hide. Dr Omar then encountered the difficulties with retrieving the medical records herself from Medserv once the GMC requested copies.

111. The Tribunal considered whether Dr Omar's evolving reasons for the issues with the dates on the letters and the wrong addresses damaged her credibility. It noted that her initial account focused on a perceived fault of her secretary in the transfer of data. She later volunteered technical issues with the Medical Practice Management system. Dr Omar said that she worried about the data protection factors in having paper copies of medical records, and that moving to an electronic service and relying on others to manage that had led to matters which have spiralled resulting in her now finding herself before her regulator.

112. The Tribunal found that Dr Omar provided a consistent account throughout cross examination. The Tribunal considered that any minor variations in her accounts could be explained by English not being her first language.

113. The Tribunal also noted from an unredacted part of Mr C's expert report that at times the focus for the GMC investigation was in respect of the *'private record keeping practices of Miss Omar described in the Rule 7 response'*. The Tribunal considered that Dr Omar's concern was in respect of an issue broader than solely Patient A's medical records, and explained why she was not entirely able to explain what the situation was until she had legal advice.

114. In any event, Ms D, confirmed in her witness statement that there was a transfer of records at that time which caused disruption in relation to the record keeping. The Tribunal was unable to explore the effect of Ms D's shortened notice period on Dr Omar's subsequent problems, due to her (Ms D) not being available to give evidence.

115. The Tribunal noted that Dr Omar's account of record retrieval was largely confirmed by the account of Ms F who provided written and oral evidence as to the efforts that she and Dr Omar took to recover the missing records. The Tribunal had regard to several emails sent in relation to the missing data:

Email from Medesk to Dr Omar and Ms F, dated 25 May 2021:

> *"Thanks very much for your time and attention today. I hope everything we discussed was clear.*

Regarding insurers and invoicing in Medesk, we will need to know more about the following:

1. Which insurers Miss Omar works with

2. Price lists for all services covered by the insurers, including excess

With that information, we can proceed with a tutorial on how to work with insurers, invoicing, billing and associated analytics, e.g. for aged receivables and suchlike."

Email from Dr Omar to Medesk, dated 25 May 2021:

"I work with all insurance companies each one of them has deferent fees for new and follow-up as for procedure fee.

self pay procedures are taken by the hospitals including my fee

for each patient there excess are different as well as their allowance

I am happy to use your system for invoices but we need a bit of time to learn how to use the system for booking, uploading the information's then we work with you to set up the invoices

my previous secretary [Ms L] is going to send all my previous data on Google drive to [Ms F] and you please make sure to upload them as soon as possible because I need them on my coming clinics and lists. If you both can do the last 5 months 1st then the others."

Email from Ms F to Medesk, dated 20 July 2021:

"Could you please let Miss Omar have an update on when her old data might be ready on Medesk? I can see a lot of the patient data has been uploaded but Miss Omar also needs the documents and previous letters."

Email from Medesk to Ms F, dated 20 July 2021:

"We are currently in the deployment phase of the upload, which means that the hard part has been done and we are effectively waiting for the data to transfer itself onto your Medesk account.

I would expect this process to take no longer than a few more days, and most likely it'll be quicker. I shall inform you immediately upon completion of the transfer."

Email from Medesk to Ms F, dated 9 September 2021:

I have been told by our IT team that all of Miss Omar's data is visible in Medesk now. I am investigating why this wasn't the case already, but you can rest assured that it is the case now.

116. Ms F also told the Tribunal that she and Dr Omar needed time to adjust and learn a new system. This was two years before the GMC investigation and they were still attempting to retrieve whatever patient records they could. At a much later point Dr Omar learned that Patient A's records had not been retrieved.

117. She also confirmed that she had been instructed by Dr Omar to check with Patient A's GP which was evidenced by email correspondence produced with her written statement. This too was unsuccessful.

118. This problem of record retrieval suggested to the Tribunal there may have been issues with the proper distribution of patient letters. Even if Ms D's USB stick with the data was uploaded, it still called into question whether Ms D had sent out the 4 letters to appropriate addressees as Dr Omar assumed they had been. There was no evidence before the Tribunal however to support or refute this. Insofar as that related to the GP practice, it appeared the letters Dr Omar re-wrote on, 11 November 2020, 16 December 2020 and 31 March 2021, were addressed to 'Beckenham Beacon', the building where Cator Medical Centre, Patient A's GP practice, was located. In addition, the discharge letter emailed from Cator Medical Centre originated from Sloane Hospital, dated 12 December 2020.

119. The lack of any clinic letters being available at Cator Medical Centre suggested there may have been issues with the distribution of letters at that earlier time, and this factor supports the reason why it was difficult for Dr Omar to retrieve Patient A's records from the GP Practice. The Tribunal observed that the clinic letters were also missing from the Sloane Hospital. The Tribunal recognised that, at least in terms of the clinic letters, they did not appear to have been distributed to the places where they should have been. As far as Dr Omar's copies were concerned, that reasoning has already been well rehearsed in respect of the difficulties with Medserv and Medesk. On this basis, the Tribunal accepted that Dr Omar had run out of options as to how she could get Patient A's medical records for the GMC.

<u>The reconstruction of the letters at the Hospital</u>

120. The Tribunal had regard to the three letters which Dr Omar re-wrote, dated 1 November 2020, 16 December 2020 and 31 March 2021, and reminded itself as to their appearance, content and construction.

121. It noted that in her oral evidence, Dr Omar's account of secretarial and practice management issues were was probed in detail. However, her contention that she had run out of options in retrieving the records demanded due to these difficulties was not substantially undermined nor did she develop her evidence to any degree. She was frank in conceding that

she knew it was her responsibility to supply records to the GMC as this was a private hospital. Whilst accepting responsibility for them being missing, she said she could not check every note of every single patient, that this was standard procedure with every secretary and that they should know what is expected.

122. Dr Omar's account that after the two emails and a telephone call from Ms H requesting the information she felt very stressed and anxious the Tribunal found understandable. Her account that the pressure to provide drove her to start dictating the letters was less understandable to the Tribunal. She accepted in cross examination that she should have told the GMC that she did not have any of Patient A's medical records but felt she could not say that, with the stress and anxiety she had.

123. In her oral evidence, Dr Omar repeated her written account that she re-wrote the letters as summaries, but they came out as letters. She said it was her intention to write a summary of each event. Her evidence was that she had not checked any of the dates or the information of the GP Practice after the secretary had added them as was the normal practice of the secretary but had just asked her secretary to put it on headed paper. Mr Barton put it to Dr Omar that she was intending to send this letter to an unknown named Doctor at Beckenham Beacon. Dr Omar denied this and said '*No*', she wanted to send it only to the GMC and denied it was a fake letter. She said she knew that Patient A already had the original letter and she just wanted to send the information to the GMC to help the investigation. She said that was the case for all three letters.

124. Dr Omar acknowledged that the letter dated 16 December 2020 was a more detailed account. She said however that this was proof that she was doing a summary as she refers to events after the Procedure, but that she had not changed or added anything. Dr Omar said in her oral evidence that she would just look at the content of the letter as opposed to the date and address, that she instructed her secretary to input the date and correct GP address.

125. In her witness statement, Dr Omar also stated that:

> *"34. On the evening of 7 November 2022, my new Secretary, [Ms F], sent to me via email the four letters I had dictated earlier that day from Ms [B]'s office. The email from [Ms F] to me, timed at 2121 on 7 November 2022, appears at page 300 of the Hearing Bundle. In the email, [Ms F] asks me to check the letters attached, which once approved she would then transpose onto letterhead and print off, along with the notes, and drop everything off to the Nuffield on the Friday."*

126. In her oral evidence, Ms F confirmed this account in respect of receiving the letters which are the subject of the Allegation from Dr Omar.

127. The Tribunal had regard to a chain of emails between Dr Omar and her secretary:

Email to Dr Omar from her secretary, dated 7 November 2022:

> *"Please see attached. If you could check the typing, once you are ok with it I will put it all on the letter head and print off all the notes, and then drop it off to Nuffield for you before Friday."*

Email from Dr Omar to her secretary, dated 7 November 2022

> *"Can you put header on my letter on each of the letter separately"*

Email to Dr Omar from her secretary, dated 8 November 2022:

> *"Please see attached – on your headed paper now"*

Email from Dr Omar to Ms H at the GMC, dated 8 November 2022 (with above email thread)

> *"Dear [Ms H]*
>
> *This is the records I have*
>
> *If you need any more information's please contact me…"*

128. It was the case of the GMC that this chain of emails between Dr Omar and her secretary were sent to the GMC accidentally, whereas it was Dr Omar's evidence that she has forwarded it deliberately with the attached letters as she had nothing to hide. The Tribunal considered that if Dr Omar had intended to conceal the recent construction of the letters, she would have exercised particular care to ensure this email thread was not forwarded.

129. Ms F's oral evidence on the pertinent issues concerning the problems related to the retrieval of records on the practice management systems and how the re-written letters came to be addressed and dated, the Tribunal found was entirely consistent with Dr Omar's. In relation to the problems with the availability of data on Medesk on 20 July 2021, she was able to confirm the delay until 9 September 2021 when the data became available and that this would have been in respect of thousands of patients' records. She said that after 9 September 2021, there were times when she needed to look up a previous patient's information and sometimes the patient data was available, but there were occasions where the letters were not available.

130. She further confirmed in her evidence that in relation the letters of 11 November 2020, 16 December 2020 and 31 March 2021 she was not told to insert the dates but that it was standard practice when she typed any medical letter to include the GP details and also insert a date, either of when the consultation took place or when the operation took place. Ms F further confirmed that Dr Omar did not tell her to put in the date or GP address, she said however that she did not recall where she got the date from to put on the letter but that she imagined it would have been on the dictation she received. In respect of the address, Ms

F said that she had access to the patient appointment system whereby she could look up the patient, their personal details and their GP details and that would be where she would have obtained that information from.

131. Under cross examination from Mr Barton, Ms F confirmed that she started working for Dr Omar on 17 May 2021 and still works for her now. The Tribunal observed that she was questioned closely about the transfer to Medesk early on in her time as Dr Omar's secretary and her knowledge of the previous system (Medserv). She confirmed she had never used Medserv but whilst she was learning the job she could access the old system to obtain patient information. She said she was not able to say whether there were patient documents missing from Medserv.

132. As indicated earlier, the Tribunal considered that Ms F's oral evidence was consistent with her written statement, and where she provided additional detail, it confirmed Dr Omar's account in locating Patient A's documents either from a medical practice management system or other sources such as the patient's GP practice.

133. The Tribunal noted that Ms F confirmed that she inserted the dates and addresses on the letters as per the dictation she had received from Dr Omar. She said that she was not told or instructed to do that. Dr Omar told the Tribunal she subsequently did not check the date or addresses. The Tribunal considered that this would be a matter for it to determine based on its view of Dr Omar's credibility, integrity and good character.

134. In relation to how the letters came to be constructed, the Tribunal also took into account the evidence of Ms B who provided the Sloane Hospital records to Dr Omar at her request.

135. In her witness statement, dated 12 December 2023: Ms B stated:

> *"9. I confirm that I provided notes to Dr Omar after Dr Omar requested the patients file from myself. notes which I provided to Dr Omar were contemporaneous and I can confidently say would have included the patient's 'pathway'; clinical notes around the incident involving the fluid overload. These would have been contemporaneous operation notes, the consent and discharge letter, as well as observations. I cannot say for certain that file would contain all clinic letters pertaining to the patient because although consultants are required to send all clinic letters to the hospital for inclusion in patients files, I am aware of incidents of non-compliance. This is monitored and addressed through the hospitals audit programme.*
>
> *10. I have been asked by the GMC whether I observed Dr Omar re-write any clinic letters for. I do not recall the letter being typed in my presence…"[90]*

136. In her oral evidence Ms B clearly expressed her very high regard for Dr Omar. Ms B said that they (the Sloane Hospital) had an AFP audit, and they observed Dr Omar's practice and said that it was of a gold standard. She also said she could not recall seeing Dr Omar dictate from the notes in her shared office.

137. The Tribunal considered that because Ms B did not recall Dr Omar re-writing or re-dictating the letters did not mean that it did not happen. The Tribunal considered that based on its existing findings, it preferred Dr Omar's recollection and consider it less credible that Dr Omar would have removed the patient records from Ms B's office.

138. The Tribunal accepted the account of Dr Omar that these letters were intended to be summaries, and that the 16 December 2022 letter was intended to be a summary of what happened, not just a summary of the retrospective entry. Dr Omar was aware that the original letters still existed when she produced the re-written letters which suggested to the Tribunal it was less plausible that she produced these in order to deceive or as fake replications. The evidence surrounding the circumstances in which the letters came to be added and addressed also did not support the GMC case as to Dr Omar's state of knowledge.

139. The Tribunal determined that the GMC had not discharged its burden of proving that Dr Omar knew that the date upon which the letters were actually written was not made clear. It considered the evidence indicated it was as probable that Dr Omar had produced the letters exercising poor judgement, and was careless and lacking transparency.

140. The Tribunal therefore found paragraph 7bii of the Allegation not proved.

Paragraph 8 of the Allegation

8. When you rewrote the letter as described at paragraph 6.b the content of it was materially different to the original version of that letter and you:

    a. failed to indicate on the letter that the content of it was materially different to the original version of that letter; **Determined and found not proved**

    b. knew that the content of it was materially different to the original version of that letter. **Determined and found not proved**

141. The Tribunal then went on to consider the content of three letters themselves, dated 11 November 2020, 16 December 2020 and 31 March 2021. It noted the stem of the allegation in which it stated that the content of the letters were 'materially different'. It recalled that counsel for the GMC and the Doctor had confirmed that paragraphs a and b of the allegation failed if the GMC did not prove material differences.

142. The Tribunal had regard to the original letters and the re-rewritten ones. It noted that it was obvious the re-written letter of 16 December 2020 was longer than the original version, that it was more detailed and contained more clinical information and follow up information than the original. It observed that it was a much fuller account of the Procedure and follow up. For example, the original letter described that Patient A had a resection and that there was a fluid overload, whereas the re-written letter explained why the complications during the Procedure occurred and that Patient A had a fluid overload. It detailed the extent of the overload, how she was treated then and thereafter, that she was transferred and mentioned the hospital investigation.

143. The Tribunal had regard to the narrative set out in its findings in respect of paragraph 7 of the Allegation particularly of how Dr Omar provided the letters and why she needed to produce them in the manner she did.

144. The Tribunal then referred to Mr C's expert report and noted that the stem of this allegation was based on his opinion that the letters were 'materially different'. He opined:

> *"This letter has clearly been rewritten, and, if the email conversation in the bundle… refers to this letter, then this occurred in November 2022 – nearly two years after the event. The content of the letter is materially different to the 'original' letter … At the very least, I would expect that a rewritten letter would contain the date on which it was written, and an explanation for why there is a new letter in the records (even if, for example, said explanation was that the original had been deleted)."*

145. The Tribunal noted however, this position was not maintained in his oral evidence. Mr C accepted under cross examination that the material clinical information was the same and that it was fairly obvious that they were two different letters. He said that the data in the letters could not be correct because the letter was dated 16 December 2020. He noted there was reference to things that happened after 16 December 2020, and he would have expected a rider to be submitted with that letter to say it was re-written because the original was unavailable for whatever reason. He said that was essentially where his criticism lay.

146. When asked whether his position remained the same in relation to all three letters and whether there was any distinction to draw between them, the Tribunal noted that it was Mr C's expert opinion that the letters were *"materially very, very similar"* and that where Dr Omar explained the differences between the letters, some of the issues with secretarial support and practice management software, did appear to be a very reasonable explanation as to why the letter had to be re-dictated. He reiterated that his criticism centred on the fact that that letters were submitted as originals effectively rather than with an explanation saying why they were re-written.

147. The Tribunal concluded that in essence, the GMC's expert witness had, in his oral evidence, yielded on the opinion he had provided in his expert report and conceded that the content of the re-written letters was not materially different to the original letters. The Tribunal was therefore of the view that the GMC had not discharged its burden in respect of the stem of paragraph 8 of the Allegation.

148. The Tribunal therefore determined that when Dr Omar re-wrote the letters described at paragraph 6.b, the content of it was not materially different to the original version of that letter. The Tribunal reminded itself of its findings at paragraph 7 of the Allegation and in particular Dr Omar's intent behind the re-writing of the three letters including the one which is the subject of this paragraph of the Allegation. It concluded that Dr Omar therefore could not have known that the content of the letter was materially different to the original version. In those circumstances, she could not have a duty to indicate on the letter that the content of it was materially different to the original version of the letter and consequently could not be found to have failed in that duty.

149. The Tribunal therefore found paragraphs 8a and b of the Allegation not proved.

Paragraph 10a(iv) of the Allegation

10. When you acted in the manner described at paragraph 9 you:

a. failed to indicate to the GMC when providing a copy of the letters outlined at paragraphs 6.a to 6.c:

iv. that the content of the letter at paragraph 6.b. was materially different to the original; **Determined and found not proved**

150. The Tribunal determined that by reason its findings as set out in respect of paragraph 8 of the Allegation, paragraph 10a(iv) cannot be found proved.

151. The Tribunal therefore found paragraph 10a(iv) of the Allegation not proved.

Paragraph 10b of the Allegation

10. When you acted in the manner described at paragraph 9 you:

b. knew the matters outlined in paragraph 7.b and/or 8.b.

Determined and found proved in respect of paragraphs 7bi and iii of the Allegation
Determined and found not proved in respect of paragraphs 7bii and 8b of the Allegation

152. The Tribunal reminded itself that Dr Omar admitted that she knew the letters were written in retrospect (paragraph 7bi) and that the letters had not been sent to Beckenham Beacon (paragraph 7biii). The Tribunal had found however that Dr Omar did not know the date upon which the letters were actually written was not made clear (paragraph 7bii), for the reasons stated. It noted that Dr Omar admitted that she provided a copy of the letters she re-wrote to the GMC on 8 November 2022 (paragraph 9). Paragraph 8 of the Allegation was found not proved and therefore falls away in respect of paragraph 10b of the Allegation.

153. The Tribunal therefore determined that paragraph 10b is found proven in relation to paragraphs 7bi and iii of the Allegation by reason of Dr Omar's admission, and not proved in relation to paragraphs 7bii and 8b of the Allegation by reason of its previous findings.

Paragraph 11a, b and c of the Allegation

11. Your actions at paragraphs:

    a. 6 were dishonest by reason of paragraph 7;
    Determined and found not proved

    b. 6.b were also dishonest by reason of paragraph 8;
    Determined and found not proved

    c. 9 were dishonest by reason of paragraph 10.
    Determined and found not proved

154. The Tribunal recalled Mr Barton's submissions in relation to the GMC's case on the rewritten letters. His contention was that *"[She] engaged in a course of deliberate and planned dishonesty…Those 3 letters were forgeries pure and simple as they purported to be something they were not*." It noted that Dr Omar had made admissions of failings in relation to these letters. However, the Tribunal reminded itself that based on the test for dishonesty in the case of *Ivey v Genting*, Dr Omar is not judged by the Tribunal solely on her actions. The Tribunal must first determine Dr Omar's state of mind at the time of the events. It recognised that its findings in respect of these paragraphs would rely heavily on its earlier conclusions as to Dr Omar's overall credibility and integrity. It considered that in relation to paragraphs 7 and 8, it has already found that when Dr Omar re-wrote the three letters in retrospect, she did not know the date upon which the letters were actually written was not made clear, nor that she knew the re-written letters were materially different to the original letters.

155. The Tribunal had largely found credible Dr Omar's state of knowledge and her account as to how the letters came to be generated. It also accepted that Dr Omar had felt under great pressure driving her to take the action that she did as she could not immediately supply

the letters the GMC had requested. The Tribunal recognised that this pressure would be especially powerful for a consultant who was held in such high esteem by their colleagues and was described to be the "gold standard" in terms of compliance, by the GMC witness, Ms B.

156. The Tribunal was satisfied that Dr Omar's intent was not to deceive, but was clearly ill-conceived and misjudged. It considered it plausible that the pressure and stress levels had affected Dr Omar's state of mind, such that the correct action to have told the GMC that she did not have Patient A's medical records did not occur to her. The Tribunal considered that it was credible that Dr Omar's long career without any regulatory input may have contributed to her panic when the GMC investigation started, and she was requested to produce the medical records.

157. In respect of Dr Omar's state of knowledge, the Tribunal has already accepted Ms F evidence as to how the format of the letters, with dates and addresses, were produced. In the context of paragraph 8 of the Allegation, the Tribunal found no embellishment or enhancement to the re-written letters, which assisted the Tribunal on Dr Omar's stated intent.

158. The Tribunal recalled the high regard Ms B held Dr Omar in as she expressed in her oral evidence. In addition, when considering Dr Omar's credibility, it reminded itself of her good character and the testimonial evidence before it, set out earlier in the Determination.

159. The Tribunal noted Dr Omar's admissions to her multiple failure in paragraphs 7 of the Allegation in respect of the re-written letters with the result that the recipient could have been misled about the nature and timings of these re-written letters. However, having regard to the second limb of the *Ivey test*, the Tribunal was satisfied that an ordinary, decent person appraised of all the facts of this case could conclude that Dr Omar's actions in respect of both paragraphs 11a and 11b of the allegation were misjudged and careless but not dishonest.

160. The Tribunal again relied upon its earlier findings in respect of Dr Omar's intent. It found that the GMC had not proven that she had an intent to conceal or deceive. The Tribunal determined that for the same reasons as it has set out in respect of paragraphs 11a and b of the Allegation, it found paragraph 11c of the Allegation not proved.

Paragraphs 12a and b of the Allegation

12. On 06 June 2023 you wrote an email ('the Email') to Ms B as outlined in Schedule One when:

a. the content of the Email had the potential to influence the evidence that Ms B provided to the GMC; **Determined and found not proved**

b. you knew or ought to have known that the content of the Email had the potential to influence the evidence that Ms B provided to the GMC. **Determined and found not proved**

161. The Tribunal noted that the GMC's had accepted at the outset of the case that the "influence" referred to in the Allegation had to be "inappropriate" In his closing, Mr Barton fairly accepted that this allegation was far less clear cut. He argued that the application of the principle of cross admissibility was important to its consideration. In particular if we were to find dishonesty and a propensity to cover up in the context of earlier Allegations, these would be relevant to the consideration of this Allegation.

162. The Tribunal first had regard to the email sent by Dr Omar to Ms B on 6 June 2023, which can be found at Schedule One:

> *"Dear [Ms B]*
> *Do you mind if you send an email to the lady in GMC who asked about the data and information's?? I lost*
> *That I managed to find it all secure with confidential passwords and Dow loaded in a secure system*
> *I can shaw you tomorrow if you want to see it by your self*
> *Is better to come from you than me.*
> *Thank you"*

163. The Tribunal had regard to Ms B's witness statement but noted that she did not however address this matter in it.

164. The Tribunal noted that the GMC's case was based around a series of emails in 2023. The Tribunal had regard to the following email correspondence:

Dr Omar received the following email from Mr M, dated 30 May 2023 @8:32

> *"Thank you. Given the investigation, we advise all witnesses to refrain from communicating with other individuals.*
>
> *As and when there are any developments, we will write further."*

Dr Omar received the following email from Mr M, dated 26 May 2023 @12:48:

> *"[Ms B] has forwarded the below mentioned character reference. However, you should not be communicating with witnesses during the GMC investigation. You will be given an opportunity to provide any comments and/or character references at the conclusion of the evidence collection process."*

Dr Omar sent the following email to Mr M, dated 26 May 2023 @1.31pm

> *"I am so sorry I didn't communicate with any one but I thought the risk manager asking me to send it to you*
>
> *Sorry it is my mistake*
>
> *Thank you for your advise"*

Dr Omar sent the following email to Mr M, dated 26 May 2023 @22:11:

> *"I just wanted to reiterate that I was asked by [Ms B] to send you the reference as apparently the GMC advised it should be emailed from me.*
>
> *Is this not the advice that was given?"*

Dr Omar received the following email from Ms K, Clinical Services Manager, dated 24 May 2023 @2:31

> *"Please find below the reference I sent to [Ms B]. Please let me know if I can be any `assistance. I understand this may be a difficult time for you but I am sure if will all be settled very soon. If you need any one else to write a reference let me know so that I can get that organised. Remember you are a very good gynaecologist which nobody can take it away from you"*

And in another email chain:

Ms B sent an email to Ms N (GMC Paralegal) in which she forwarded the reference from Aleyamma Eappen, on 24 May 2023 @14:33:

> *"In the meantime, I have a character reference for Miss Omar from our interim theatre manager Aley below."*

Ms N responded to Ms B on 26 May 2023 @10:52am:

> *"…I just wanted to let you know that we cant exhibit any character references to your statement. Any character references must be submitted to the GMC by Dr Omar. I would just remind you to not discuss your evidence or that you are acting as a witness in the GMC investigation with anyone else while the investigation is ongoing.*
>
> *We have received the policy documents from [Ms O] yesterday so many thanks for arranging these to be sent…"*

Ms B sent an email to Ms N on 26 May 2023 @11:27

"Hi [Ms N] …just working from home today as a failsafe measure and I am just going over the statement now and will send this to you today. I have not discussed this with anyone, and our theatre manager thought she was doing a reference for a new job the consultant has which she indicated when she wrote I wish her the very best, but of course I will ask Miss Omar to send any references she has to the GMC separately. Thank you for your guidance, and I will get this over to you asap today"

Ms N responded to Ms B on 26 May 2023 @13:39

"…thanks for giving some background re: the character reference."

Ms B sent an email to Ms N on 6 June 2023 @13:58:

"Hi [Ms N] sorry I am off of work … I will get round to reading this and I have caught up on some emails and can see one from Miss Omar and she has now got all of her patient data and it was secure with patient passwords, she has downloaded it on to a secure system.

Therefore, does this impact the case against her?"

165. Whilst it was the GMC's case that Dr Omar was improperly contacting witnesses, the Tribunal observed that in relation to the email in respect of Ms K, this indicated that Ms B had contacted Ms K for a reference for Dr Omar. Ms B then sent that reference to Dr Omar and Dr Omar forwarded that email on to Mr M at the GMC. This did not indicate to the Tribunal that Dr Omar had actively sought references from potential witnesses. She had not contacted anyone apart from some interactions she had had with Ms B. It noted that confusingly, on the one hand Mr M was telling Dr Omar not to contact potential witnesses and warning her about forwarding a reference, and on the other hand Ms N was telling Ms B that the references would have to come from Dr Omar, immediately suggesting the need for contact between Ms B and Dr Omar.

166. In Dr Omar's email to Mr M on 26 May 2023 @1.31pm Dr Omar seemed very confused and not entirely clear what she should do as it was Ms B who asked her to forward the reference.

167. In her witness statement, Dr Omar stated:

"47. With regards to allegation 12, namely that I interfered with a GMC witness, [Ms B], my representatives have responded to this allegation in the form of my solicitor's email of 4 January 2024, which is annexed to this statement as Exhibit "KO2". I deny absolutely any attempt to interfere or influence any individual into saying

anything they would not otherwise have said. The email in question from me to Ms [B] …is dated 6 June 2023. In addition to that response, I should add that when CQC came to inspect the Sloane hospital, they commented that I was the best consultant to apply WHO criteria. [Ms B] kindly suggested to me that I send that comment to the GMC on the email, to which I responded that it would be better coming from her rather than me, as the Investigation Officer was telling me off about what I was sending into the GMC. Further, upon receipt of the GMC allegations, I again reviewed MedDesk and found the original letter which was sent to the patient. I advised Ms [B] of this and she suggested that I send it to the GMC, however, I asked Ms [B] to do so due to the GMC Investigation Officer's previous comments."

168. The Tribunal considered that having looked more closely at the sequence of emails on these matters, they appeared to support Dr Omar's' account. It is obvious that neither Mr M nor any other representative from the GMC had provided an official list of potential witnesses to Dr Omar with whom she was to avoid contact.

169. In her oral evidence Dr Omar confirmed that at the time she sent the email on the 6 June 2023, she did not know Ms B was a potential witness for the GMC. Her account was that Ms B called her in the morning of 6 June 2023 when Dr Omar had an oncology clinic. Ms B told her that a lady from the GMC was calling her about the data but that Ms B did not know what it was about and was therefore asking her about it. Dr Omar said in her evidence that when she finished her clinic, she sent Ms B the email (at Schedule One) and said that it was better to come from Ms B as she was told not to contact anyone.

170. Dr Omar was clear in her evidence she did not know who the witnesses were in relation to the investigation of Patient A's records and saw Ms B every day in the canteen and in going to work but did not know she should not talk to her. Dr Omar said that Ms B asked one of the theatre managers to send a reference, that she had not asked for that and Ms B then included her in the email. She said she was confused about what contact she was allowed to have with the GMC which is why in the email she referred to the fact that the information to be sent to the GMC was better coming from Ms B than her.

171. The Tribunal then took account of the evidence of Ms B noting that she made no reference to this matter in her witness statement. In her oral evidence Ms B was questioned in respect of the email and any influence or inappropriate interference may have had on her.

172. The Tribunal noted that from her perspective, Ms B said that she was not influenced by Dr Omar's email. She was very complimentary about Dr Omar's professional standards and she had no belief or impression that Dr Omar was inappropriately trying to interfere in her evidence in any sense. Her evidence was that Dr Omar was "*just a human*" who has recovered her system and wanted to convey that to the GMC. She confirmed that at no stage did Dr Omar tell her not to tell the GMC that Dr Omar had contacted her and she was aware

of the GMC investigation as she had been asked to provide a statement, but that she did not know what it actually pertained to.

173. The Tribunal determined that the situation outlined in the email stream was confusing and was not a firm basis for establishing that there were clear instructions as to who Dr Omar could and could not contact, in particular Ms B. It was not satisfied that the GMC had demonstrated that Dr Omar had tried to influence Ms B inappropriately or otherwise. It noted that Ms B told the GMC that she had not '*discussed this with anyone',* and the Tribunal considered that by just conveying what Dr Omar has told her, and indeed indicating in the email that the information was what Dr Omar had told her, it was not clear how Ms B could be, or was, influenced by the email. Both Dr Omar and Ms B were very transparent in their emails and the Tribunal did not consider the GMC had advanced evidence on which it could rely of any attempt by Dr Omar to influence Ms B.

174. The Tribunal reminded itself that it was the GMC's own view that the evidence for this allegation was less clear cut and it noted that it had not accepted the GMC contention that Dr Omar had a tendency to supply the GMC with fake or false information.

175. The Tribunal considered the GMC had produced no evidence that Dr Omar was actively contacting potential witnesses or actual witnesses to influence the investigation and it accepted Dr Omar's explanation concerning the comment in the email of 6 June 2023, that '*better come from you than me'.*

176. When considering Dr Omar's state of mind, the Tribunal was also satisfied that the GMC had not proven to the requisite standard that she knew Ms B was a witness. The email exchange set out above demonstrates clearly that Dr Omar was confused about who she could and could not speak to.

177. The Tribunal therefore determined that the content of the email from Dr Omar on 6 June 2023 did not have the potential to influence the evidence that Ms B provided to the GMC, nor that she knew or ought to have known that the content of the email had the potential to influence the evidence that Ms B provided to the GMC.

178. The Tribunal therefore found paragraph 12a and b of the Allegation not proved.

The Tribunal's Overall Determination on the Facts

179. The Tribunal has determined the facts as follows:

1. On 16 December 2020 you performed a hysteroscopic resection of fibroid ('the Procedure') upon Patient A during which Patient A developed a fluid overload of approximately four litres. **Admitted and found proved**

2. On a date or dates between 16 December 2020 and 06 April 2021 you:

a. retrospectively altered an entry in Patient A's medical records relating to the Procedure in that you overwrote the record of fluid output noted in the operation/treatment notes from '5.20' to '7.20L';
Admitted and found proved

b. arranged for the altered record of the Procedure described at paragraph 2.a above to be provided to Patient A.
Admitted and found proved

3. When you acted in the manner described at paragraph 2.a you knew that the entry you made was an incorrect record of fluid output during the Procedure.
Determined and found not proved

4. When you acted in the manner described at paragraph 2.b you knew that you were providing inaccurate information to Patient A as to the extent of the fluid overload that developed during the Procedure.
Determined and found not proved

5. Your actions at paragraphs:

a. 2.a were dishonest by reason of paragraph 3;
Determined and found not proved

b. 2.b were dishonest by reason of paragraph 4.
Determined and found not proved

6. Between a date on or around 22 December 2020 and 8 November 2022 you:

a. rewrote a letter in retrospect dated 11 November 2020 regarding Patient A which was readdressed to Beckenham Beacon;
Admitted and found proved

b. rewrote a letter in retrospect dated 16 December 2020 regarding Patient A which was readdressed to Beckenham Beacon;
Admitted and found proved

c. rewrote a letter in retrospect dated 31 March 2021 regarding Patient A which was readdressed to Beckenham Beacon.
Admitted and found proved

7. When you acted in the manner outlined at paragraphs 6.a-6.c, you:

a. failed to indicate on the letters:

i. that the letters were written in retrospect;
Admitted and found proved

ii. the date upon which the letters were actually written;
Admitted and found proved

iii. that the letters had not been sent to Beckenham Beacon;
Admitted and found proved

b. knew that:

i. the letters were written in retrospect;
Admitted and found proved

ii. the date upon which the letters were actually written was not made clear; Determined and found not proved

iii. the letters had not been sent to Beckenham Beacon.
Admitted and found proved

8. When you rewrote the letter as described at paragraph 6.b the content of it was materially different to the original version of that letter and you:

a. failed to indicate on the letter that the content of it was materially different to the original version of that letter;
Determined and found not proved

b. knew that the content of it was materially different to the original version of that letter. Determined and found not proved

9. On 08 November 2022 you provided a copy of the letters outlined at paragraphs 6.a to 6.c to the GMC. Admitted and found proved

10. When you acted in the manner described at paragraph 9 you:

a. failed to indicate to the GMC when providing a copy of the letters outlined at paragraphs 6.a to 6.c:

i. that the letters were written in retrospect;
Admitted and found proved

ii. the date upon which the letters were actually written;
Admitted and found proved

iii. that the letters had not been sent to Beckenham Beacon; **Admitted and found proved**

iv. that the content of the letter at paragraph 6.b. was materially different to the original; **Determined and found not proved**

b. knew the matters outlined in paragraph 7.b and/or 8.b.
Determined and found proved in respect of paragraphs 7bi and iii of the Allegation
Determined and found not proved in respect of paragraphs 7bii and 8b of the Allegation

11. Your actions at paragraphs:

a. 6 were dishonest by reason of paragraph 7;
Determined and found not proved

b. 6.b were also dishonest by reason of paragraph 8;
Determined and found not proved

c. 9 were dishonest by reason of paragraph 10.
Determined and found not proved

12. On 06 June 2023 you wrote an email ('the Email') to Ms B as outlined in Schedule One when:

a. the content of the Email had the potential to influence the evidence that Ms B provided to the GMC; **Determined and found not proved**

b. you knew or ought to have known that the content of the Email had the potential to influence the evidence that Ms B provided to the GMC. **Determined and found not proved**

Determination on Impairment - 05/02/2025

180. 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 Omar's fitness to practise is impaired by reason of misconduct.

The Evidence

181. The Tribunal has taken into account all the evidence received during the facts stage of the hearing. It also received a Stage 2 reflective witness statement from Dr Omar, dated 3 February 2025, and a Stage 2 defence bundle which included Dr Omar's CV; appraisal documents for 2023 and 2024; and Continuous Professional Development ('CPD'), various.

Submissions on behalf of the GMC

182. Mr Barton referred the Tribunal to the relevant legal principles when considering misconduct. He submitted that in light of the Tribunal's findings of fact, Dr Omar's previous positive good character, the passage of time since the relevant events, and the contents of her reflective statement, he would not be making any positive submissions that Dr Omar's fitness to practise is currently impaired.

183. Mr Barton submitted that when determining the issue of impairment, the Tribunal must adopt a two-stage approach, whether there has been misconduct and, if there has, whether as a result of that misconduct, the practitioner's fitness to practise is impaired. He said misconduct was a separate and distinct concept from impairment, and that a finding of misconduct did not invariably lead to a finding of impairment. Mr Barton submitted that misconduct could be classed as an act or omission falling short of what would be proper in the circumstances. He referred the Tribunal to the principles set out in the case of *Roylance v GMC [2000] 1 A.C. 31*, that in order to make a finding of misconduct, the Tribunal must determine that the facts found proved were a serious departure from the standards of conduct expected from a practitioner, and that the conduct must be that which would be regarded as deplorable by fellow practitioners.

184. Mr Barton said that Dr Omar admitted, and the Tribunal found that she performed the hysteroscopic resection of fibroid on patient A, during which patient a developed a fluid overload. He said that this allegation was admitted in full and included the fact this was an overload of approximately 4 litres. Mr Barton said that during the hearing it was Dr Omar's case that the overload was not 4 litres and based on all the circumstances it was less than that, which was why Dr Omar altered the operation note. Mr Barton reminded the Tribunal that Dr Omar admitted that she retrospectively altered the entry on Patient A's medical record in relation to the fluid output and changed the operation note from 5.20 to 7.20 litres, and arranged for the altered record to be provided to Patient A, at the patient's request.

185. Mr Barton reminded the Tribunal that in relation to the re-writing of the three letters, Dr Omar failed to indicate that they were written in retrospect, the date they were actually

written, and that they were not sent to the Beckenham Beacon GP practice, and the Tribunal found that she knew that that they were written in retrospect and not sent to the Beckenham Beacon practice.

186. Mr Barton referred the Tribunal to Good Medical Practice (2013) ('GMP') where it states what is expected of all doctors registered with the GMC and observed that where it states *'you must',* there is an overriding duty or principle. He said that where '*you should'* is used, it is either as an explanation of how the overriding duty or principle is to be met, or where the overriding duty and principle will not apply. Mr Barton submitted that paragraphs 19 and 71 of GMP were engaged in this case, namely:

> *"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."*
>
> *"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 write or sign are not false or misleading.*

187. Mr Barton said that in respect of the operation note, Dr Omar accepted that she retrospectively altered one copy of her signed operation note whilst leaving the copy held by the hospital unaltered. He reminded the Tribunal that it accepted Dr Omar's account as to the circumstances in which that occurred and have not found any dishonesty, and that the altered account was the correct one. He submitted however that the result was that two copies of Dr Omar's notes were then kept in different locations with different entries, and that Dr Omar accepted that that was not good practice. Mr Barton said that paragraph 19 of GMP also applied to the three letters, and that the Tribunal may also consider paragraph 71 of GMP could apply to the rewriting of those letters and the provision of those letters to the GMC.

188. Mr Barton accepted that, in the light of the Tribunal's findings, the opinion of the GMC expert, Mr C, was no longer applicable in respect of the operation note. He said this was because Mr C's assertion that it was seriously below the standard expected of a reasonable consultant in obstetrics and gynaecology, was dependent upon a finding of dishonesty, which the Tribunal had not made.

189. Mr Barton submitted that it was therefore a matter entirely for the Tribunal whether that conduct fell below the expected standards, and if so, how far. He reminded the Tribunal of some of the language it used to describe Dr Omar's actions in respect of the provision of the three letters to the GMC. Mr Barton reminded the Tribunal that it had determined that

Dr Omar had exercised poor judgement, had been careless and lacked transparency, and had described her actions as misjudged and careless, and that the recipient could have been misled about the nature and timings of those re-written letters. Mr Barton submitted that those views reflect the potential risks of retrospective alterations and creation of documents.

190. In respect of impairment, Mr Barton reminded the Tribunal that he was not making any positive submissions, but that when considering current impairment, the Tribunal must look forward and not back and that it would have to take into account the way in which the practitioner has acted or failed to act in the past. He referred the Tribunal to the case of *Meadow v GMC [2006] EWCA Civ 1390 (26 October 2006)*, and the classic test of impairment which is found in the Fifth Shipman Report prepared by Dame Janet Smith. He said that test was followed by Silber J in the case of *Cohen v GMC [2008] EWHC 581 (Admin) (19 March 2008*). He submitted that the statutory overriding objective must inform the Tribunal's approach to the issue of impairment, namely, to protect and promote 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 the profession. He submitted that it was also highly relevant in determining if a doctor's fitness to practise is impaired as to whether the conduct which led to the allegations were easily remediable, have been remedied and whether they were unlikely to be repeated.

Submissions on behalf of Dr Omar

191. Mr Mahmood reminded the Tribunal that at this stage of the hearing, it was for the Tribunal to decide, exercising its own independent judgment, and that there was a need to keep in mind the relevant legal test and its specific findings, but nothing beyond that. He said it was a two-stage process, firstly to address the issue of misconduct and secondly, to address the issue of impairment. He said that there was no statutory definition of misconduct, but that the case of *Nandi v General Medical Council [2004] EWHC 2317 (Admin) (04 October 2004)* assisted on this point, and in various other cases that it has to be serious misconduct, namely conduct which is regarded as deplorable by fellow practitioners. He said that was the relevant threshold which needed to be satisfied as far as misconduct is concerned.

192. Mr Mahmood agreed that the correct case law was that of *Meadow*, as had been mentioned by Mr Barton, which stated that the purpose of these proceedings was not to punish the practitioner for past misdeeds but was to protect the public against acts or omissions of those who are not fit to practise and that the Tribunal looks forward and not back.

193. Mr Mahmood submitted that the findings were based largely upon the admissions made by Dr Omar namely that following a complication in a procedure which resulted in a fluid overload, Dr Omar altered an operation note. He said that the Tribunal specifically found there was no benefit to changing the fluid deficit and that at the time, Dr Omar's focus was on the patient and that resolving the differences in two copies of the operation notes slipped her mind. He reminded the Tribunal of its findings that after the operation, Dr Omar took responsibility for the overload, that she made no attempt to cover this up and had found her account for the change to the operation note to be credible.

194. Mr Mahmood reminded the Tribunal that in respect of the three re-written letters, Dr Omar had always admitted that she rewrote them; that she failed to indicate in the letters that they were written in retrospect; that they had not been sent to the GP Practice; that she knew they were written in retrospect; and that they had not been sent to the GP. He also referred the Tribunal to its findings that it found Dr Omar's explanation to have been consistent throughout and that it recognised that the circumstances which led to the creation of the letters stemmed from the issue with record retrieval. He said the Tribunal recognised that Dr Omar was very stressed when she re-dictated letters and was likely exercising poor judgement, carelessness and lacking transparency, which Dr Omar has never denied. He said the Tribunal had accepted that Dr Omar's intention at the time was to create summaries and that when the letters were typed, she deliberately copied in the GMC to the email trail, which included the fact that the letters had been re-typed.

195. Mr Mahmood reminded the Tribunal that it accepted that when the letters were created, Dr Omar only looked at the contents of the letters, rather than the dates or the addresses contained within them, and that the letters were dictated in Ms B's office. Further that the letters were not materially different to the originals. Mr Mahmood submitted that Dr Omar has accepted the mistake she made in re-writing letters without making clear that these were written retrospectively.

196. Mr Mahmood submitted that when considering whether Dr Omar's conduct met the threshold of being deplorable so as to amount to serious misconduct, when taking into account the background to the Tribunal's findings, the answer must be no. Mr Mahmood said that he did not challenge the submission of Mr Barton in respect of paragraphs 19 and 71 of GMP as they have been engaged. He submitted however that the GMC's case was largely prefaced on the fact these letters were written at a time when the doctor ought to have known better, that they were dishonest and, in those circumstances, misleading the GMC. Mr Mahmood submitted that Mr C rolled back from his previous conclusions that the conduct fell seriously below acceptable standards because he accepted and recognised that the

letters were not materially different. He said that this undermined the suggestion that there was still serious misconduct given the context and given the background.

197. In respect of current impairment, Mr Mahmood submitted that Dr Omar has practised medicine for 45 years without a single blemish on her record, and that the Tribunal has heard evidence, which it accepted, that she generally performs to a gold standard, or at least, that was the evidence of Ms B. He said that when Dr Omar was investigated by the hospital, she took full responsibility for the incident. He said there was no evidence of previous concerns and that there was not even a small risk of future repetition. In terms of insight and remediation he referred the Tribunal to Dr Omar's statements, her Rule 7 response, her appraisal documents, her Responsible Officer statements and her CPD. He referred the Tribunal to the two probity courses Dr Omar completed, in March 2024 and October 2024. Mr Mahmood submitted that Dr Omar has full insight and has fully remediated her conduct. He said Dr Omar was truly remorseful for what has happened. He submitted that Dr Omar's conduct did not satisfy the threshold of serious misconduct, but that if the Tribunal were against him on that, there was no evidence of current impairment of fitness to practise.

The Relevant Legal Principles

198. 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 its judgement alone. The Tribunal was mindful of the two-stage process to be adopted: first whether the facts as found proved amounted to misconduct, and that the misconduct was serious, and then whether the finding of that misconduct which was serious, could lead to a finding of impairment.

199. The Tribunal had reminded itself that it must determine whether Dr Omar's fitness to practise is impaired today, taking into account her 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.

200. Whilst there is no statutory definition of impairment, the Tribunal was assisted by the guidance provided by Dame Janet Smith in the Fifth Shipman Report, as adopted in the High Court in *CHRE v NMC and Paula Grant [2011] EWHC 297 Admin* with regard to commonly occurring features that are likely to be present when impairment is found:

> *''a. Has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*

b. Has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or

c. Has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or

d. Has in the past acted dishonestly and/or is liable to act dishonestly in the future.''

201. The Tribunal also had regard to the case of *Cohen v GMC [2008] EWHC 581* where the court said, "*it must be highly relevant in determining if a doctor's fitness to practise is impaired that first his or her conduct which led to the charge is easily remediable, second it has been remedied and third that it is highly unlikely to be repeated."*

202. The Tribunal further reminded itself of the statutory overarching objective which is 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 the profession.

The Tribunal's Determination on Impairment

Misconduct

203. In determining whether Dr Omar's fitness to practise is impaired by reason of misconduct, the Tribunal reminded itself of its findings at Stage 1. It also had regard to the submissions of Mr Barton and Mr Mahmood.

Retrospectively Altered Operation Note

204. The Tribunal noted the GMC's concession that in respect of paragraph 1 of the Allegation, which Dr Omar had admitted and was proved, it was not the GMC's case that this amounted to misconduct. The Tribunal did not therefore give any consideration to misconduct in respect of paragraph 1.

205. In relation to paragraphs 2a and b of the Allegation, which alleged Dr Omar retrospectively altered Patient A's operation note and then arranged for the altered record to be provided to Patient A, the Tribunal reminded itself that Dr Omar admitted this allegation but it had not found that there was any intention on the part of Dr Omar to mislead nor that her actions had been dishonest.

206. It noted Mr Barton's concession that Mr C's opinion that the altering of the record would amount to serious misconduct, was conditional on dishonesty being found, which it had not been. The Tribunal reminded itself that when the explanation for the alteration was put to him, it was Mr C's oral evidence that it was important to make sure that what is written in the notes is accurate. It recalled his indication that it was important that if notes were altered, both copies needed changing or a note made to that effect, as otherwise there would be a situation in which one copy is incorrect and one copy that is correct. In his view, it was important to the Patient's management that a message got through to say what the actual estimate was, and this should have been communicated to the next hospital.

207. The Tribunal also recalled that Mr C conceded that Dr Omar was in a very difficult situation, there was an emergency, and that whilst the ultimate responsibility may lie with the consultant, there were certainly many mitigating factors. The Tribunal again noted that Mr C's criticism was that Dr Omar did not annotate the carbon copy with an explanation for the amendment, and that she did not also make the same change to the top copy. It has already determined that given the circumstances, the focus would have been on the clinical condition of the patient rather than administration.

208. 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."*

209. The Tribunal was of the view that based on the above paragraph of GMP and Mr C's oral evidence, Dr Omar had a duty to make sure both copies of the operation note were accurate. It noted that it had accepted that Dr Omar could not find the top copy of the operation note at the time. It had further accepted her account of the circumstances set out at Stage 1, namely the chaos, panic and stress of the situation at that time, which meant finding the top copy was not a priority for her at that time. The Tribunal reminded itself that Mr C accepted as plausible the circumstances and the explanation which Dr Omar gave. Based on his concession, the Tribunal had accepted her explanation as to why the top copy of the operation note was never corrected.

210. The Tribunal also recalled Dr Omar's oral evidence that she would have liked to have changed both copies of the operation note and noted her acceptance in her Stage 2 statement that she should have corrected the top copy of the operation note.

211. The Tribunal noted again the mandate in paragraph 19 of GMP, the opinion of the GMC expert and Dr Omar's own concession set out above. It considered that taking these into account, Dr Omar should have ensured both notes were amended. However, it noted

that the most serious allegations in respect of the alteration had been found not proven and reminded itself of its findings in respect of the difficult circumstances prevailing at the time the notes were made. Having regard to those factors, it considered that members of the public and fellow practitioners would understand how the omission came about and would not conclude Dr Omar's conduct to be so unacceptable as to amount to serious misconduct.

The Three retrospective rewritten letters

212. The Tribunal noted Dr Omar's admissions to her multiple failures relating to the three retrospective letters, which could lead to the recipient being misled about the timings of when these letters were written and as to whether they were sent to Patient A's GP. It noted its previous findings that whilst Dr Omar was not dishonest in relation to those failings including failing to check their contents properly and clearly indicating that they were written retrospectively, it had found that she had exercised poor judgement, was careless and lacked transparency.

213. In addition to paragraph 19 of GMP set out above, the Tribunal had regard to paragraph 71a of GMP, in which it stated:

> *"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 write or sign are not false or misleading.*
>
> *a. You must take reasonable steps to check the information is correct…"*

214. The Tribunal again reminded itself what Mr C's expert opinion was in this regard:

> *"…… At the very least, I would expect that a rewritten letter would contain the date on which it was written, and an explanation for why there is a new letter in the records (even if, for example, said explanation was that the original had been deleted).*
>
> *… If it is shown that Dr Omar rewrote the clinic letters without explanation or clarification, then this is also seriously below the standard expected…"*

215. It noted again his oral evidence that at the very least "*he would have expected a rider to be submitted with that letter to say it was re-written because the original was unavailable for whatever reason. He said that was essentially where his criticism lay."*

216. The Tribunal again considered the background and circumstances of this case, namely the documented problems Dr Omar had experienced trying to locate and retrieve the original records for Patient A and the pressure she had felt under to produce them for her regulator. It noted Dr Omar's concession in her evidence that she should simply have said to the GMC that she did not have them, or when she produced these three retrospective letters make it clear that they were retrospective or include a rider. It noted again the evidence on how the dates and addresses came to be inserted on the letters and her failure to check those details as well as the content of what she dictated. The Tribunal considered this especially important when they were being produced for the purpose of providing them to the GMC as a summary for its investigation. The Tribunal considered the duty to check the information was correct was hers and did not lie with her secretary.

217. The Tribunal considered that whilst it had not found an intention to mislead, the lack of any rider or annotation that the letters were written in retrospect meant the letters had the capability of misleading.

218. The Tribunal found that the failings admitted by Dr Omar in respect of the retrospectively produced letters which she provided to the GMC, engaged paragraphs 19 and 71 of GMP. She had not taken reasonable steps to check the dates on the letters were correct and by failing to mark the documents as constructed retrospectively, had failed in the duty to be transparent and accurate which she was required to be, especially with her Regulator.

219. Therefore, although Dr Omar's actions were confined to a single event and the Tribunal had not found her dishonest in relation to the writing and submission of the retrospective letters but rather careless and misguided, the Tribunal determined that the failings admitted in relation to their construction and provision to the GMC were significant departures from GMP. It considered these amounted to misconduct which was serious and which fellow practitioners would consider unacceptable and had the potential to affect the public's confidence in the medical profession.

Impairment

220. Having found that some of the facts admitted amounted to misconduct which was serious, the Tribunal went on to consider whether, as a result of this, Dr Omar's fitness to practise is currently impaired by reason of her misconduct.

221. In determining whether a finding of current impairment of fitness to practise is necessary, the Tribunal looked for evidence of insight, remediation and the likelihood of

repetition, bearing in mind the three elements of the overarching statutory objective. It considered that insight and remediation are important in order for a doctor to recognise areas of their practice and behaviour that require improvement, and to take appropriate and relevant steps to address them, thus reducing the likelihood of repetition.

222. The Tribunal first considered evidence of Dr Omar's insight. It noted that in relation to the production of the re-written letters, Dr Omar made admissions in her Rule 7 statement, her statement for this hearing and at the hearing itself through formal admissions and in her oral evidence. In relation to the whole event arising out of difficulties during the Procedure, the aftermath and subsequent investigation, albeit focused more on clinical aspects, Dr Omar has clearly reflected often and deeply as evidenced in her appraisals. It observed, for example, the comments of Dr P, Dr Omar's Responsible Officer, dated 2 November 2022, in which he stated:

> *"The doctor has reflected on the incident a great deal. Although the theatre nurse with her was highly experienced, she accepts that she was in charge and should have been explicitly clear about setting the limits on the pressure and acceptable fluid deficits. She has presented the case at a clinical governance meeting for learning and has discussed it at her last appraisal. At the start of every case during the safety huddle she now is very clear about the pressure and monitoring of fluid deficient and follows national guidance.*
>
> *The doctor has met with patient and family has fully apologised."*

223. On the specifics of the issue which has led to a finding of misconduct, it noted the following in her reflections from her Probity and Ethics Course, 19 October 2024:

> *"I continue to dictate concisely and in a timely manner. During dictation, with a use of a template, I identify myself, list all relevant clinical information as well as agreed actions. I ensure exact dates of events as well as clear instructions on file destinations. I continue to proof read all transcribed texts carefully and sign off on documentation before they are marked as complete."*

224. In her reflections from her 'Good Practice in Record Keeping for doctors' training, dated 26 October 2024, she reflected:

> *"I was able to reflect on my own practice and the current case - key factors I have strived to improve are keeping an accurate and precise record of communication as well as consenting in a meticulous manner. I also was able to take on board the importance of a proportionate approach to the detailing of my record keeping.*

Following the incident, I found myself documenting extensively to prevent any further issues. I have changed my practice to enhance record keeping by utilising the following;

1. Using a clinical record keeping checklist that helps in ensuring compliance with GMC guidance. The checklist includes all relevant findings, discussions, the decisions made and agreed actions.
2. Ensuring all documentation is accurately timed and dated when dictated - if this has happened in retrospect this is explicitly documented.
3. After discussing operative risks with patients I follow up all cases by sending the patient digital consent information using the Concentric system when appropriate. If patients prefer I will provide them with paper leaflets and if they require further communicative support this is arranged.
4. I continue to safe guard all patient information as per the data protection guidelines."

225. In respect of Dr Omar's insight, the Tribunal also had regard to her Stage 2 statement, in which she stated:

"17 I genuinely tried to help the GMC in their investigation by producing what I thought would amount to summaries of the events in the three letters I dictated in November 2022. My intention was to help, but on reflection I fully recognise the mistake that I made. I should not have:

17.1 Dictated the said letters without making clear that they were not contemporaneous to the events in question. I should have identified the dates on which the letters were dictated, and I should have been open about the fact that I no longer had access to the letters in November 2022.

17.2 Made any amendment to the operation note, without including an appropriate context to explain the basis for this.

18 I should have been completely open in my behaviour…"

226. The Tribunal considered that Dr Omar has shown good and effective insight into her failures over an extensive period and that she has put in practice behaviours and actions to address that conduct to ensure it does not happen again.

227. The Tribunal considered that Dr Omar's actions were clearly capable of remediation and noted that she has completed targeted CPD, including courses in probity and ethics and record keeping, in respect of the matters which arose as part of this case.

228. The Tribunal again reminded itself of written and oral evidence provided at an earlier stage in the hearing about Dr Omar's good character and the high esteem in which she is held. It noted again the extensive testimonial evidence referred to and quoted from at Stage 1 of this hearing which demonstrated her excellence as a clinician who is complimented on her honesty and integrity. It observed that the matters before this Tribunal stemmed from a one-off incident in an otherwise unblemished 45 year career, arising from what the Tribunal had found to be difficult and stressful circumstances. It noted the passage of time since these events, and that there has been no repetition of the misconduct.

229. The Tribunal was therefore satisfied that through her CPD, her reflections, various statements, early admissions, and based on the evidence she has provided to this Tribunal, that Dr Omar has gained full insight into her actions to address her misconduct.

230. The Tribunal was also satisfied that Dr Omar has remediated her misconduct in the work she has undertaken to address her misconduct. This, together with the evidence of her previous unblemished career and powerful testimonials satisfied the Tribunal that the risk of repetition was negligible.

231. The Tribunal carefully considered and balanced the three elements of the statutory overarching objective. It accepted that there were no patient safety concerns in this case.

232. The Tribunal had regard to whether a finding of impairment was necessary on public interest grounds in order to uphold proper professional standards. It reminded itself of the finding it had made in relation to misconduct and the fact that these issues had been the subject of regulatory proceedings. The Tribunal considered this finding of misconduct and these proceedings are sufficient to highlight to the wider profession that Dr Omar's conduct was unacceptable.

233. The Tribunal also noted that its finding that Dr Omar's misconduct was serious and had the potential to affect the public's confidence in the profession. However, the Tribunal reminded itself of the substantial level of insight and remediation demonstrated by Dr Omar and her acceptance of responsibility during the early stages of the regulatory process and admissions at this hearing. It noted again that these factors indicated to the Tribunal that there was a very low risk of repetition. It concluded that a fully informed member of the public, made aware of these factors and her long and previously unblemished career would be sufficiently satisfied and reassured that Dr Omar's responses were appropriate to offset concerns prompted by her misconduct. It took into account that the public would appreciate and welcome her express commitment to the continued practice of medicine.

234. Therefore, the Tribunal determined that public confidence in the medical profession would not be undermined if a finding of impairment was not made in the particular circumstances of this case.

235. The Tribunal therefore determined that Dr Omar's fitness to practise is not currently impaired by reason of misconduct.

Determination on Warning - 05/02/2025

236. As the Tribunal determined that Dr Omar's conduct amounted to misconduct, but that her fitness to practise is not impaired, it considered whether in accordance with s35D(3) of the 1983 Act, a warning was required.

Submissions on behalf of the GMC

237. Mr Barton submitted that a warning in this case would be both proportionate and appropriate, in the light of the Tribunals finding that the provision of the re-written letters to the GMC without any sort of rider or explanation represented a significant departure from good medical practice. He then referred the Tribunal to the relevant paragraphs of the 'Guidance on Warnings' (April 2024) it should consider when determining whether to issue a warning, but that it was a matter for the Tribunal.

238. Mr Barton reminded the Tribunal of its findings at Stage 1 and Stage 2 in respect of the three retrospective letters that Dr Omar had re-written, and that it determined that Dr Omar breached paragraphs 19 and 71 of GMP. He said the Tribunal stressed the importance of the context in which these letters were provided particularly when they were being produced for the purpose of providing them to the GMC as a summary for its investigation, that the Tribunal considered the duty to check the information was correct was Dr Omar's. He said the Tribunal found the re-written letters lacked any rider or annotation and that they were therefore capable of misleading her regulator, albeit that was not the intention and there was no dishonesty. Mr Barton said the Tribunal found Dr Omar did not take reasonable steps to check the dates on the letters were correct and by failing to mark the documents as constructed retrospectively, it found the doctor had failed in the duty to be transparent and accurate, which she was required to be.

239. Mr Barton submitted that all those factors supported the issuing of a warning in this case. He noted the Tribunal was satisfied that Dr Omar has full insight, has remediated, and the risk of repetition was extremely unlikely. Mr Barton submitted however that a warning

was necessary here to have the effect of highlighting to the wider profession that this type of conduct is unacceptable.

Submissions on behalf of Dr Omar

240. Mr Mahmood submitted that a warning was not necessary nor proportionate in light of the Tribunal's findings, in particular on impairment, insight and remediation. He submitted that the only purpose for issuing a warning in this case would be to benefit the wider profession to highlight that this kind of behaviour will not be tolerated.

241. In respect of the factors the Tribunal must consider if the realistic prospect test is not met, Mr Mahmood submitted that the Tribunal has found that Dr Omar's fitness to practise is not currently impaired, has full insight, has apologised, has genuine regret for what has happened, has previous good history, is of previous impeccable character, that there has not been any repetition, that this was a single incident, that the Tribunal found the likelihood of the concerns being repeated as negligible, and that Dr Omar had fully remediated.

242. Mr Mahmood said that the GMC appeared to be suggesting that because there was a significant departure from GMP, that in itself should be enough for the Tribunal to conclude that a warning was necessary. Mr Mahmood submitted that those were merely factors that would enable the Tribunal to consider the imposition of a warning. He referred the Tribunal to the Guidance of Warning in respect of the principle of proportionality, weighing the interests of the public with those of the practitioner. He reminded the Tribunal of the context of this case, that it was dealing with a 68-year-old lady who, during a time of intense stress, and without any malicious intent, dictated 3 letters retrospectively intending them to be summaries. He said Dr Omar made admissions and recognised that in doing so that was wrong. He said the Tribunal recognised that Dr Omar has full insight into all her failures and has taken steps to address her conduct. Mr Mahmood submitted that in those circumstances a warning was not necessary.

243. Mr Mahmood said that the GMC suggested that a warning should be imposed as a deterrent, not necessarily just for Dr Omar, but for the wider public interest. He submitted that the finding of serious misconduct in itself was sufficient to satisfy the concerns Mr Barton urged upon the Tribunal and that there was no requirement to go beyond that. He said that at the impairment stage the Tribunal concluded that a fully informed member of the public made aware of these factors and her long and previously unblemished career would be sufficiently satisfied and reassured that Dr Omar's responses were appropriate to offset concerns prompted by her misconduct, that it took into account the public would appreciate and welcome her express commitment to the continued practice of medicine. Mr Mahmood

submitted that its Stage 2 determination itself was sufficient to mark the seriousness of what has happened and act as a major deterrent in any event.

244. Mr Mahmood submitted that it would not be proportionate to impose a warning solely on the basis that a deterrence was required. He said Dr Omar retired from the NHS in 2023 and is currently working part time in a private setting three and a half days a week. He said there was a very considerable concern here that if a warning is issued, there was a risk that this may impact on her employment in that private setting.

The Tribunal's Determination on Warning

245. The Tribunal had regard to the overarching objective, as well as the particular circumstances of this case, and applied the principle of proportionality, weighing the interests of the public with those of Dr Omar. The Tribunal bore in mind that the reputation of the profession as a whole is more important than the interests of any individual doctor.

246. The Tribunal considered the *Guidance on warnings*, in particular paragraphs 16, 17 and 20, 26 and 32, which 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*
> - *there is a significant cause for concern following an assessment of the doctor's performance.*
>
> *17. There is no definition of 'significant' in the Medical Act or in the Fitness to Practise Rules. The paragraphs below are therefore intended to help decision makers, at both the investigation and hearing stages, consider whether a warning is appropriate."*
>
> *"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."

247. The Tribunal noted that there has been a significant departure from Good medical practice and that she it had found that she had exercised poor judgement, was careless and lacked transparency. It was of the view however, that these concerns had been mitigated by the context of the circumstances in this case, that this was a one-off incident in an otherwise unblemished 45-year career, arising from what the Tribunal had found to be difficult and stressful circumstances and that there was no intention to mislead. It also considered that these concerns had been addressed with a finding of misconduct.

248. The Tribunal was also of the view that were Dr Omar to repeat the misconduct, a finding of impaired fitness to practise would likely follow. It noted however that the set of circumstances which Dr Omar found herself in over an unblemished 45 year career, were unlikely to occur again and that it found the risk of repetition to be negligible.

249. The Tribunal also noted that the guidance sets out that when warning is issued there is a need to record formally the particular concerns. The Tribunal was mindful that it had already formally recorded its concerns at Stages 1 and 2 of these proceedings.

250. When considering proportionality, the Tribunal reminded itself of its decision at Stage 2 in which it concluded that Dr Omar's responses were appropriate to offset concerns prompted by her misconduct and that it took into account that the public would appreciate and welcome her express commitment to the continued practice of medicine.

251. The Tribunal considered that issuing a warning for a deterrent effect was not therefore needed either in order to send a message to Dr Omar that this type of conduct was unacceptable, nor was it required to send a message to the wider public. The Tribunal was however of the view that to issue a warning as a deterrent effect would be wholly disproportionate in the contract and all the circumstances in this case.

252. The Tribunal determined that Dr Omar has sufficiently met all those factors as set out at paragraph 32a-g. The Tribunal has already found Dr Omar had a substantial level of insight and remediation, she expressed regret and remorse for her conduct and in her Stage 2 statement stated, *"I fully recognise the importance of accurate record keeping, and I remain sincerely sorry for everything that has happened."* Dr Omar is of previous good history with no previous regulatory findings and the Tribunal reminded itself that these matters stemmed from a one- off isolated incident of which there has been no repetition. Dr Omar has taken rehabilitative and corrective steps taken and has fully remediated her misconduct. She has also provided testimonial evidence which has testified to her good character and how she is held in high esteem.

253. The Tribunal weighed all the evidence before it and determined that to issue a warning in the circumstances of this case would be wholly disproportionate and that one was not required.

254. The Tribunal concluded therefore that the circumstances of this case did not warrant a formal response, and it would therefore not be appropriate to issue a warning.

255. There is no interim order to be revoked.

256. That concludes the case.

ANNEX A – 23/01/2025

Application on the admissibility of evidence

257. On Day 3 of the hearing, the GMC expert, Mr C, Consultant Obstetrician and Gynaecologist, began providing his oral evidence. Following examination in chief by Mr Hugh Barton, Counsel on behalf of the GMC, and cross examination by Mr Ghazan Mahmood, Counsel on behalf of Dr Omar, Mr Barton re-examined Mr C. During his re-examination, Mr Mahmood objected to Mr Barton asking Mr C questions concerning a hospital Incident Management report concerning the procedure Dr Omar carried out on Patient A and specifically the retrospective entry of Dr Omar dated 22 December 2020 in the report.

Submissions on behalf of the GMC

258. Mr Barton submitted that he wished to invite Mr C to consider, in view of the explanation that has been provided including the chaos around the alteration to the operation sheet, whether one might expect Dr Omar to include in those retrospective entries a fuller account and a reference to a possible difference between the entries and the reasons for that. This was especially the case since this was being investigated by the hospital. He said that he did not want to go into the substance or the conclusions of the investigation. Mr Barton said that he was happy to confine his questions to Dr Omar's retrospective entries. He said that he did not accept that the passages identified were beyond the scope of the of the expert's expertise.

Submission's on behalf of Dr Omar

259. Mr Mahmood submitted that Mr C had not addressed the matter of the significant incident in his expert report, nor had Mr C been asked to speak to this matter in Mr Barton's examination in chief. He said that he himself had not raised the matter in his cross examination, so Mr Barton was not entitled to re-examine Mr C on new matters that had not already been put to him and which were not a part of his expert report. He submitted that this is one of those cases where the GMC appeared to be introducing errors in the evidential process and then compounding those errors by further errors. He said that the expert's responsibility was to give an expert opinion on the matters that are relevant to the case. The only reason he raised the issue of chaos was because of the point made by the expert which goes beyond his expertise talking about motivation and professional embarrassment. He said this was not within the expert's domain.

260. Mr Mahmood submitted that the matter of retrospective entries was not even mentioned in his report. He also said that it was not the case that the GMC get the last say by introducing new evidence.

Further submissions on behalf of the GMC

261. Mr Barton submitted that were his application to ask Mr C about the significant incident rejected, he would then invite the Tribunal to consider an application to adduce new evidence for this topic to be explored with the expert considering scenarios related to honest mistake borne out of chaos compared to entries made not in a state of chaos.

Further submission's on behalf of Dr Omar

262. Mr Mahmood submitted that he objected to the application to adduce new evidence and submitted that if that application were granted, the evidence of an expert should be given in writing so that the doctor has the chance to look at the report and address them and give instructions. He submitted that it was not fair to admit new evidence on what would be the fourth day of the hearing.

263. He said that also when dealing with the issue of unfairness, the defence did not have an expert on the issue because they were happy to confine the position to the GMC's expert, the majority of which they did not challenge anyway. Mr Mahmood said that the defence did not challenge the expert's opinion, but where he raised issues on factual matters, this matter was for the Tribunal, not for him.

Tribunal's Approach

264. The Tribunal considered this application to adduce evidence pursuant to Rule 34(1) of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'), namely:

> *"(1) The Committee or a Tribunal may admit any evidence they consider fair and relevant to the case before them, whether or not such evidence would be admissible in a court of law."*

265. In relation to its consideration of the issue of fairness, the Tribunal bore in mind that the purpose of re- examination is to give a witness the opportunity to explain or clarify matters elicited in cross examination and is therefore limited to only those matters that were raised during cross examination although additional evidence may be adduced insofar as it bears on matters arising in cross examination.

266. In relation to adducing further oral testimony from a witness, the LQC advised that normally a witness statement will stand as their evidence in chief and permission to adduce fresh evidence should only be granted if there is a good reason not to confine the evidence of the witness to the contents of their witness statement.

267. The Tribunal also took account of the fact that expert evidence is generally used to assist them when the case in front of them involves matters on which they do not have the requisite technical or specialist knowledge.

268. The above approach was provided in writing to parties and no objection was made.

The Tribunal's Decision

269. In respect of the application of Mr Barton for permission to examine Mr C's opinion about the contents of the Incident Management Report including Dr Omar's retrospective notes, the Tribunal noted that Dr C was not taken to or asked about these during cross examination by Mr Mahmood. It further observed that Mr Mahmood's examination was confined to eliciting answers from Mr C on the operation note completed on the day of the operation and the letters drafted by Dr Omar in November 2022. These were the areas on which Mr C had been instructed by the GMC to provide an opinion and which are the subject of the Allegation. The Tribunal also noted that the Incident Management Report was not referred to or discussed in either of the unredacted parts of Mr C's expert reports nor had he previously been instructed to venture an opinion on it. The above being the case, seeking to put parts of the contents of the Incident Management Report to Mr C, suggested to the Tribunal that Mr Barton was going beyond simply dealing with or clarifying matters raised in cross examination.

270. The Tribunal also considered Mr Barton's associated contention that, even if Mr Mahmood had not referred to the Incident Management Report, his (Mr Mahmood's) examination of Mr C related to the effect the chaotic situation surrounding the medical emergency may have had on the completion of the operation note. Mr Barton submitted that this permitted him to contrast that situation with Dr Omar's statement in the Incident Management Report. The Tribunal were not attracted to that argument. It determined that permitting the Incident Management Report to be put to Mr C for an opinion would be raising a new matter and go beyond assistance with the rectification or clarification of existing testimony given by the expert.

271. The Tribunal therefore upheld the objection made by Mr Mahmood to the line of questioning by Mr Barton.

272. In view of the above determination, the Tribunal then considered Mr Barton's associated application to adduce fresh oral testimony from Mr C by way of reopened examination in chief to allow him to contrast notes made under pressure and entries in a report not made under the same circumstances.

273. The Tribunal noted that clearly the existence of the Incident Management Report is not a new matter which has just been discovered during cross examination. It noted that the GMC did not instruct Mr C to address himself to this contrast in either of his expert reports; if it considered it to be a pertinent issue then it clearly could have done so. The evidence which Mr C had before him to produce his expert report included the documentation upon which he could have provided his opinion, but one which he had not been tasked with.

274. The Tribunal accepted Mr Mahmood's submission that, if the application was granted, the Defence were entitled to have the expert's view reduced to writing for their consideration. It noted his submission that up to now, they had generally been content with the expert's opinions save where he had ventured into areas which they did not regard as appropriate. Since this was an area of dispute, the Tribunal recognised that were it to grant the application, the hearing would have to be adjourned to allow time for Mr C to produce a further albeit short expert report to address this matter as it had not been addressed in his expert reports already in front of the Tribunal. Mr Mahmood would then need to take instructions and the defence may then need to appoint their own expert to respond. This would inevitably result in delay and the Tribunal considered it was neither in the public interest nor in the interests of justice to grant the application.

275. In any event, the Tribunal reminded itself of its approach to its consideration of this issue namely that expert evidence is generally used to assist them in relation to matters on which they do not have the requisite technical or specialist knowledge. The Tribunal was of the view that the issue on which Mr Barton on behalf of the GMC sought to adduce further evidence was not self-evidently a matter on which the opinion of an expert was required but was one on which the Tribunal could form a view aided by submissions as necessary.

276. The Tribunal therefore determined to reject the application.

ANNEX B – 23/01/2025

Application on hearsay evidence

1. On day 3 of the case, Mr Barton notified the Tribunal that Ms D would not be able to attend for cross examination as had been requested by the Defence under Rule 34(9A) of the Rules. Mr Mahmood indicated to the Tribunal that whilst he did not object to her witness statement being admitted, he reserved his position to make submissions on the weight to be attached to the statement in view of the witness not attending.

2. The Tribunal noted the provisions of Rule 34(1) of the Rules:

> *"The Tribunal may admit any evidence they consider fair and relevant to the case before them, whether or not such evidence would be admissible in a court of law"*

3. The relevance of the statement not being in dispute, the Tribunal considered whether it would be fair to admit it. It was assisted by the factors set out in the case of *Thorneycroft v NMC [2014] EWHC 1565 (Admin)* as referred to by GMC and also *R (Bonhoeffer) v GMC [2011] EWHC 1585 (Admin)7* and *El Karout v NMC [2019] EWHC 28 (Admin)*. It considered that although the reasons for non-attendance were not strong, it would not be in the interests of the public or the doctor for there to be any delay to procure her attendance later. The evidence of the witness was not the sole and decisive evidence in support of the GMC case and, as indicated by Mr Mahmood, much of the testimony was not in dispute. It further took account of the fact that he did not object to the statement being admitted but reserved his position to address the Tribunal on weight.

4. The Tribunal therefore determined it was fair to allow the written statement of Ms D to be admitted in evidence and resolved to consider carefully what weight should be given to it in the course of its deliberation on the Facts.

SCHEDULE 1

"Dear XXX

Do you mind if you send an email to the lady in GMC who asked about the data and information's??I lost
That I managed to find it all secure with confidential passwords and Dow loaded in a secure system
I can shaw you tomorrow if you want to see it by your self
Is better to come from you than me.
Thank you"