PUBLIC RECORD

Dates: 12/05/2025 - 23/05/2025

Doctor:	Dr Mohammad MOHAMMAD
GMC reference number:	4619871
Primary medical qualification:	MB BCh 1983 Ain Shams University

Type of case	Outcome on facts	Outcome on impairment
New - Misconduct	Facts relevant to impairment found proved	Impaired

Summary of outcome

Suspension, 6 months.
Review hearing directed
Immediate order imposed

Tribunal:

Legally Qualified Chair	Mrs Julia Oakford
Lay Tribunal Member:	Ms Jo Palmiero
Registrant Tribunal Member:	Dr Juliet Bennett

Tribunal Clerk:	Ms Jemine Pemu

Attendance and Representation:

Doctor:	Present, represented
Doctor's Representative:	Mr Andrew Colman, Counsel, instructed by DWF Law
GMC Representative:	Mr Alan Taylor, 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 & Impairment - 20/05/2025

Background

1. Dr Mohammad qualified in 1983 with MB BCh from Ain Shams University in Cairo and has been practising in the UK since 1997. He was appointed as a Consultant Obstetrician and Gynaecologist in November 2012 and joined the Specialist Register in 2012. At the time of the events Dr Mohammad was practising as a Locum Consultant Obstetrician & Gynaecologist at Kings Mill Hospital (part of Sherwood Forest Hospitals NHS Foundation Trust). He had been employed there from mid July 2022 to 30 September 2022. Dr Mohammad has been practising, in a substantive post, as a Consultant Obstetrician & Gynaecologist at the Bronglais Hospital (part of Hywel Dda University Health Board, West Wales) since November 2022.

2. The Allegation that has led to Dr Mohammad's hearing relates to the care of Patient A on 5 August 2022 and Patient B on 5 September 2022.

3. On 5 August 2022, Patient A, a 32-year-old woman, attended hospital with pain in her right abdomen. She was pregnant and concerns were raised regarding a possible ectopic pregnancy. A scan of Patient A's uterus was undertaken and the scan report showed an empty sac in her uterus and a 'doughnut shaped mass' abutting her right ovary. Patient A was seen by Dr Mohammad approximately 30 minutes after the scan. He advised her that the pregnancy was ectopic and gave her three options including that she could receive an injection of methotrexate, which would lead to a miscarriage. This was undertaken imminently. Patient A then attended the hospital on 9 August 2022 and, following a blood test, she was contacted by a nurse who informed that her HCG levels had increased over 100%, which was unexpected. Another scan was undertaken on 11 August 2022. Patient A then met with a lead Consultant and was informed that her pregnancy was intrauterine, and the doughnut shaped mass had been a cyst near her ovary where the egg had been dispatched from, and she observed a yolk in the sac. Patient A was advised that there was no reverse treatment for the methotrexate and subsequent scans revealed no heartbeat.

Patient A was informed that she should not have been advised to have the injection and the HCG levels did not mean there should have been something in the sac. It was not a certain diagnosis of ectopic pregnancy and all options were not explored as to what the doughnut shaped mass could have been. Patient A subsequently had a miscarriage.

4. Patient B was a 35 year old woman in her second pregnancy. She was placed under consultant-led care at 19 weeks gestation due to her previous medical history and the timing of booking the appointment. During her pregnancy, Patient B had experienced and reported several episodes of altered (reduced) fetal movements prior to 26 weeks gestation and four episodes were noted after 26 weeks gestation. Patient B was appropriately reviewed by obstetricians on each of these admissions with appropriate referrals for scans and her care was in line with Trust guidance around altered fetal movements. On 31 August 2022, Patient B was admitted to the maternity ward with preterm pre labour rupture of membranes (PPROM) at 32+2 weeks gestation. She remained an inpatient for 48 hours and during her admission received two doses of corticosteroids, cardiotocography (CTG) monitoring and a growth scan which showed linear growth, a reduced liquor volume and normal dopplers. She was discharged with antibiotics and weekly pregnancy day care follow up.

5. On 5 September 2022, at 33 weeks gestation, Patient B attended for her first planned weekly pregnancy day care appointment following PPROM for a computerised CTG and blood test. On arrival she reported altered fetal movements and intermittent abdominal pain/cramps. It was requested that a senior review of the CTG be undertaken as it did not meet the Dawes Redman criteria. The CTG was reviewed by Dr Mohammad at 17.10 hours and he incorrectly interpreted and classified the CTG as normal. However, Dr Mohammad did not send Patient B home but arranged for her to be admitted with ongoing monitoring. Shortly after Dr Mohammad's review there was a fetal bradycardia which prompted urgent transfer to the Sherwood Birthing Unit (SBU). Upon arrival at the SBU there were difficulties in locating the fetal heart on the CTG and a bedside scan confirmed it to be 60 beats per minute (bpm). A decision was made for a Category One emergency caesarean section (EMLSCS) at 18:32hrs. A female infant was born at 18:48hrs with no signs of life. Prolonged neonatal resuscitation was required by the Neonatal team. A decision was made for transfer to the Neonatal unit (NNU) at 19:33hrs.

6. Patient B's infant remained on the NNU and was planned for neonatal transfer however, at 01:50hrs the following morning whilst preparing for transfer Patient B's infant had a cardiac arrest and became too unstable. At 04:37hrs Patient B's infant sadly passed away with her parents present.

7. The initial concerns were raised with the GMC on 18 August 2022 by Patient A through an online complaint. The Sherwood Forest Hospital Trust raised concerns with the GMC about Patient B.

The Outcome of Applications Made during the Facts Stage

8. At the outset of the hearing, the Tribunal were notified that the GMC had made an application, pursuant to Rule 28 of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'), to the Case Examiners seeking to withdraw some allegations relating to Patients A and B. This followed a discussion between the two experts and the production of a joint expert report. Prior to formally opening the case, Mr Taylor, counsel, on behalf of the GMC informed the Tribunal that paragraphs 1a, 1b,1c (all parts) and 2a of the Allegation should be withdrawn.

9. On 14 May 2025, prior to the opening of the case, Mr Taylor, on behalf of the GMC, made an application, pursuant to Rule 17(6) of the Rules to amend the Allegation to withdraw paragraphs 2c and 2d. The Tribunal was provided with an additional addendum report from the GMC expert Dr J, dated 13 May 2025. Within this addendum report Dr J revised her opinion on Dr Mohammad's standard of care in relation to the matters set out at paragraphs 2c and 2d of the Allegation and opined that the standard of care provided did not fall below the standard expected of a reasonably competent Consultant Obstetrician. Under these circumstances, Mr Taylor stated that there is no evidence that the GMC could put forward to substantiate these particular paragraphs of the Allegation and therefore asked that those paragraphs of the Allegation be withdrawn. He submitted that this amendment can be made without injustice to Dr Mohammad and it is to his benefit. Mr Colman, on behalf of Dr Mohammad, agreed with the application. The Tribunal was of the view that this amendment could be made without injustice and therefore granted the application.

The Allegation and the Doctor's Response

10. The Allegation made against Dr Mohammad is as follows:

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

1. On 5 August 2022 you were involved in the care and treatment of Patient A and you:
    a. ~~incorrectly diagnosed an ectopic pregnancy~~; Withdrawn by GMC
    b. ~~failed to give adequate consideration to alternative diagnoses such as an early intra-uterine pregnancy~~; Withdrawn by GMC

c. failed to arrange:
    i. ~~a serial beta human chorionic gonadotropin measurement after 48 hours;~~ Withdrawn by GMC
    ii. ~~a repeat ultrasound a minimum of seven days after the first scan;~~ Withdrawn by GMC
    iii. ~~diagnostic keyhole surgery (in the alternative to paragraphs 1.c.i and 1.c.ii);~~ Withdrawn by GMC
d. inappropriately prescribed methotrexate without confirming a diagnosis of ectopic pregnancy and excluding a viable intrauterine pregnancy.
Admitted and found proved

2. On 5 September 2022 at around 17:10, you reviewed Patient B's antenatal cardiotocography ('CTG') ('the 5 September CTG') and you:
    a. ~~failed to consider in your assessment the changes in variability between the 5 September CTG, and earlier CTGs~~; Withdrawn by GMC
    b. incorrectly interpreted and classified the 5 September CTG as normal;
    Admitted and found proved
    c. ~~failed to ensure delivery by way of caesarean section within 30 to 60 minutes of your assessment~~; Withdrawn under Rule 17(6)
    d. ~~made an inappropriate follow-up plan for admission and monitoring with CTGs three times a day.~~ Withdrawn under Rule 17(6)

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

The Admitted Facts

11. At the outset of these proceedings, through his counsel, Mr Andrew Colman, Dr Mohammad made admissions to all remaining paragraphs and sub-paragraphs of the Allegation, as set out above, in accordance with Rule 17(2)(d) of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended ('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.

Impairment

12. 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 Mohammad's fitness to practise is impaired by reason of misconduct.

Witness Evidence

13. Dr Mohammad provided his own witness statement, dated 28 March 2025, and also gave oral evidence at the hearing. Dr Mohammad also provided his CV to the Tribunal.

14. Dr Mohammad provided a further witness statement, dated 14 May 2025.

15. In his oral evidence, Dr Mohammad provided the Tribunal with some background into the circumstances resulting in the Allegation.

16. The Tribunal also received in support of Dr Mohammad six testimonials, all of which it has read, from the following colleagues that are aware of the Allegation made against him:

- Mr C, Consultant Gynaecologist & Cancer Lead Consultant at Hywel Dda University Health Board, dated 2 May 2025. He was a former colleague of Dr Mohammad;
- Mr D, Obstetrics and Gynaecology Consultant and Hospital Director in Bronglais General Hospital, dated 4 May 2025;
- Ms F, Obstetrics and Gynaecologist Consultant at Hywel Dda University Health Board and colleague of Dr Mohammad, dated 5 May 2025;
- Mr E, Consultant Obstetrics and Gynaecology at Bronglais General Hospital and colleague of Dr Mohammad, dated 6 May 2025;
- Ms G, Speciality Doctor in Obstetrics and Gynaecology at Bronglais General Hospital, dated 9 May 2025. She previously interviewed Dr Mohammad prior to his main Medical Interview;
- Mr H, Service Delivery Manager for Community Paediatrics and Sexual Health in Hywel Dda University health board, dated 12 May 2025. He was previously Dr Mohammad's line manager.

Expert Witness Evidence

17. The Tribunal also received reports from three expert witnesses.

18. Two expert reports, on behalf of the GMC, were received from Dr I and Dr J, relating to Patient A and Patient B respectively. They were not called to give evidence.

19. Dr I provided an expert report, dated 23 November 2023. She also provided a supplemental expert report, dated 11 March 2024.

20. Dr J provided an expert report, dated 14 February 2024. She also provided a supplemental expert report, dated 07 February 2025.

21. Professor K, on behalf of Dr Mohammad, provided two expert reports on Patient A and Patient B respectively, both dated April 2025. He was not called to give evidence.

22. A Joint expert discussion took place on 16 April 2025 based on the reports of Dr I and Professor K in relation to Patient A. A report was produced outlining areas where they agreed and disagreed.

23. A Joint expert discussion took place on 30 April 2025 between Dr J and Professor K in relation to Patient B. A report was produced outlining areas where they agreed and disagreed.

24. Dr J provided a further supplementary report dated 13 May 2025.

Documentary Evidence

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

- Patient A:
  - Patient A's online complaint, dated 18 August 2022;
  - Email from Responsible Officer Sherwood Forest Hospitals NHS Foundation Trust ('The Trust'), dated 13 March 2023;
    - Enclosing incident investigation report signed off 06 March 2023;
  - Dr Mohammad's witness statement provided as part of a serious incident investigation at Kings Mill Hospital, dated 16 September 2022;
  - Patient A medical records including scans;
  - E-mail from Sherwood Forest Hospitals NHS Foundation Trust, dated 23 October 2023, with Nursing Notes for Patient A;
  - E-mail from Sherwood Forest Hospitals NHS Foundation Trust, dated 31 October 2023, with Datix;
- Patient B:
  - Trust incident investigation report, dated 26 June 2023;
  - Coronial statement of Dr Mohammad, dated 20 September 2023;
  - Transcript of Dr Mohammad's evidence to the Coroner, dated 13 December 2023;
  - Record of inquest, dated 12 December 2022;
  - Patient B medical records;
  - Patient B's CTG's, dated 05 September 2022;

  - Patient B's Datix.
- Various Continued Professional Development – Course Booking and Certificates, including:
  - PROMPT 2023 course covering Obstetric haemorrhage, maternal collapse, impacted fetal head, PET, Shoulder Dystocia, Breech, OBS Cymru and Human Factors, dated 24 January 2023;
  - Hywel Dda University Local Health Board – Good Practice in Consent, dated 8 March 2023;
  - Royal College of Obstetricians and Gynaecologists - Early pregnancy and gynaecological ultrasound, dated 11 September 2023 – 12 September 2023;
  - Royal College of Obstetricians and Gynaecologists –Electronic Fetal Monitoring, dated 24 March 2024;
  - Hywel Dda University Health Board – Introduction to the CaPE Study, dated 14 May 2024;
  - Royal College of Obstetricians and Gynaecologists – Antenatal Computerised Fetal Heart Monitoring Agenda, undated;
  - Royal College of Obstetricians and Gynaecologists – Antenatal Computerised Fetal Heart Monitoring, dated 18 June 2024;
  - NHS Wales - CTG Reflection, dated 28 June 2024;
  - Hywel Dda University Health Board – PROMPT Update, dated 8 May 2025.
- Orbit 360 Patient Feedback, dated 23 July 2024.

26. The Tribunal did not accept an email from Professor K dated 14 May 2025 as it considered that it was not for him to opine on whether a doctor's actions would be considered deplorable.

Submissions

On behalf of the GMC

27. Mr Alan Taylor submitted that Dr Mohammad's fitness to practise is currently impaired by reason of his misconduct. He submitted that Section 1A of the Medical Act 1983 provides that the overarching objective of the General Medical Council in exercising their functions is the protection of the public. He reminded the Tribunal of the statutory overarching objectives which include: to protect, promote and maintain the health, safety and wellbeing 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. Mr Taylor submitted that all three limbs are engaged in this case.

28. Mr Taylor referred the Tribunal to the correct approach to be taken when considering impairment, highlighting the case of *Cheatle v GMC (2009) EWHC 645* where Cranston J stated (at paragraph 19): '*Whatever the meaning of impairment of fitness to practise, it is clear from the design of section 35C [of the Medical Act 1983] that a panel must engage in a two-step process. First, it must decide whether there has been misconduct, deficient professional performance or whether the other circumstances set out in the section are present. Then it must go on to determine whether, as a result, fitness to practise is impaired.*'

29. Mr Taylor referred the Tribunal to the authorities of *Nandi v General Medical Council [2004] EWHC 2317 (Admin), Roylance v General Medical Council [1999]* and *R (Remedy UK Ltd) v General Medical Council [2010] EWHC 1245 (Admin)* which give guidance as to how Tribunals are to approach the issue of misconduct. Mr Taylor submitted that Remedy established there is misconduct of two principal kinds. He submitted that the first may involve sufficiently serious misconduct in the exercise of professional practice, such that it can properly be described as misconduct going to fitness to practice. Second, it can involve conduct of a morally culpable or otherwise disgraceful kind, which may not necessarily arise in the context of the doctor's clinical practice, but it must be in the exercise of the doctor's medical calling. Mr Taylor submitted that such conduct prejudices the reputation of the profession misconduct.

30. Mr Taylor submitted that both kinds of misconduct identified in *Remedy* are present in this case. He submitted that Dr Mohammad's misconduct was in the exercise of his professional practice such that it can properly be described as going to fitness to practise. Mr Taylor submitted that this case does not involve a single, isolated clinical incident. It involves two separate incidents relating to serious deficiencies in the care of two patients in the context of Dr Mohammad's professional role as a Consultant Obstetrician & Gynaecologist. He submitted that Dr Mohammad's clinical failings were also such as to attract opprobrium and thereby bring the profession of medicine into disrepute.

31. Mr Taylor submitted, in relation to Patient A, that Dr Mohammad inappropriately prescribed methotrexate without confirming a diagnosis of ectopic pregnancy and excluding a viable intrauterine pregnancy. He reminded the Tribunal that Patient A put it in her online complaint, dated 18 August 2022: '*I have likely lost a healthy baby*.' Mr Taylor submitted that this was a tragic and devastating outcome for the patient, and she will have to live with thoughts of what might have been for the rest of her life. He submitted that it appears that this happened because Dr Mohammad rushed his consultation with the patient. This explains why Dr Mohammad encouraged Patient A to have the methotrexate injection, and why the latter was presented to the patient as, in effect, the only viable option.

32. Mr Taylor reminded the Tribunal of Dr I's assessment:

> '*The NICE guidelines also comment further on the appropriateness of Methotrexate use. Excluding an intrauterine pregnancy is an essential criterion prior to considering Methotrexate. 'Methotrexate should only be offered on a first visit when there is a definitive diagnosis of an ectopic pregnancy, and a viable intrauterine pregnancy has been excluded'*.
> …
> '*The local Trust guidelines are also in line with NICE recommendations and further help with decision making by categorising patients into 'good' and 'poor' candidates for medical management of ectopic pregnancy with methotrexate.*'
> …
> *'…prescribing a cytotoxic drug like methotrexate on a first visit without a definitive diagnosis of an ectopic pregnancy; in the presence of a 'probable' early intrauterine pregnancy is very seriously below the standard of a reasonably competent consultant Obstetrician & Gynaecologist…*'

33. Mr Taylor submitted that what Dr I describes goes beyond mere negligence. He submitted that Professor K was also of the view that '*the administration of methotrexate given on the first visit fell seriously below the standards expected for a consultant gynaecologist*.' Mr Taylor therefore submitted that Dr Mohammad's actions in inappropriately prescribing methotrexate without confirming a diagnosis of ectopic pregnancy and excluding a viable intrauterine pregnancy constitute serious professional misconduct.

34. Mr Taylor submitted, in relation to Patient B, that Dr Mohammad incorrectly interpreted and classified the 5 September CTG as normal. He referred the Tribunal to Dr Mohammad's handwritten note and the antenatal CTG assessment proforma which clearly set out that a normal CTG should have no decelerations and that decelerations are abnormal. He submitted that the Trust's guidance similarly stated: *'A normal antenatal CTG is defined as having baseline rate 110-160/min, variability 5-25 bpm, an absence of decelerations and at least two accelerations (>15 beats/min for >15 secs) in 10 minutes'*. Mr Taylor submitted that this was a basic, fundamental error which had the potential to lead to harm to Patient B's baby.

35. Mr Taylor submitted that Dr J's opinion was that '*Dr Mohammad did not correctly interpret and classify Patient B's CTG when he reviewed it at around 17:10 and his practice at this point fell seriously below the expected standard'*. He submitted that Professor K was also

of the view that '*the categorisation of the CTG at 1710 hours fell seriously below the expected standard from a consultant obstetrician'*. Mr Taylor therefore submitted that Dr Mohammad's actions in incorrectly interpreting and classifying the 5 September CTG as normal constitute serious professional misconduct.

36. Mr Taylor submitted that the facts found proved in this case are serious, these were serious departures from the expected standards, and the consequences in Patient A's case were devastating. There can be no doubt that Dr Mohammad's actions in relation to Patients A and B both individually and when taken together amount to serious professional misconduct.

37. Mr Taylor submitted that the question of impairment is a matter of judgment for the Tribunal, rather than a matter of proof. He reminded the Tribunal of the case of *Meadow v General Medical Council (2007) 1 All ER 1* where Sir Anthony Clarke MR stated, ' *…the purpose of FTP proceedings is not to punish the practitioner for past misdoings but to protect the public against the acts and omissions of those who are not fit to practise. The FTPP thus looks forward not back. However, in order to form a view as to the fitness of a person to practise today, it is evident that it will have to take account of the way in which the person concerned has acted or failed to act in the past*.'

38. Mr Taylor submitted that although remedial action may be highly relevant in relation to impairment arising from clinical errors and errors of judgment, there are some forms of misconduct which are so serious that the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made, whatever the remedial steps taken.

39. Mr Taylor directed the Tribunal to the case of *Yeong v General Medical Council (2009) EWHC 1923 (Admin)*, in which Sales J upheld the submission of counsel that, ' *a finding of impairment of fitness to practise may be justified on the grounds that it is necessary to reaffirm clear standards of professional conduct so as to maintain public confidence in the practitioner and in the profession. In such a case, the efforts made by the medical practitioner in question to address his behaviour for the future may carry very much less weight than in a case where the misconduct consists of clinical errors or incompetence*.'

40. Mr Taylor submitted that the need to uphold proper professional standards and public confidence in the profession would indeed be undermined if no finding of impairment were made in the circumstances of this case. He further submitted that reasonable and properly informed members of the public would be shocked and concerned by Dr Mohammad's actions in prescribing methotrexate without confirming a diagnosis of ectopic

pregnancy and excluding a viable intrauterine pregnancy. Mr Taylor submitted that reasonable and properly informed members of the public would also be shocked and concerned by Dr Mohammad's actions in classifying Patient B's fetal heartbeat as normal when it was obviously abnormal.

41. In terms of insight and remediation, Mr Taylor submitted that Dr Mohammad admitted the Allegation at the outset of the hearing and that he has apologised and attended relevant online courses. He submitted that it cannot be ignored, however, that Dr Mohammad has recently been practising under clinical supervision. Mr Taylor submitted that the evidence of Dr Mohammad's remediation must be seen in this light, because it impacts on the confidence that the Tribunal can have that there has in fact been complete remediation and that there is no risk of repetition. He submitted that the Tribunal cannot discount the possibility that further incidents might have occurred were the supervision not in place.

42. Accordingly, Mr Taylor submitted that, notwithstanding the evidence of reflection and remediation, the Tribunal cannot conclude that Dr Mohammad's remediation is complete and that there is no risk of repetition.

43. Mr Taylor submitted that Dr Mohammad's actions breached paragraphs 8, 11, 15, 16, and 19 of *Good Medical Practice* (2013 version) (GMP). He submitted that Dr Mohammad's actions represent serious departures from the proper professional standards expected of registered medical practitioners and require a finding of impairment to be made. Mr Taylor referred the Tribunal to the case of *Grant* and in particular the following test in relation to the issue of impairment, namely:

> *"do our findings in respect of the doctor's misconduct … show that his / her fitness to [practise is impaired in the sense that he/ she:*
>
> *(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) …"*

44. He submitted that limbs (a), (b) and (c) are engaged in this case.

45. Mr Taylor submitted that, in the circumstances, the Tribunal should find Dr Mohammad's fitness to practise impaired by reason of his misconduct.

On behalf of Dr Mohammad

46. Mr Andrew Colman submitted that the Tribunal must first decide whether each of the admitted failings amounts to misconduct. He submitted in relation to allegation 2b, this was a misdescription of the nature of the CTG trace. It was not that Dr Mohammad had mistakenly analysed the CTG as normal, but that he wrongly categorised and recorded it in that way. If it were otherwise, Dr Mohammad would not have admitted the patient for further monitoring. Mr Colman submitted that, fortunately, that mistake was not consequential, because the patient was admitted and the baby was delivered within a short time. He submitted that, although the description of the CTG was potentially misleading, nobody in fact acted upon it. The tragic death of the child was not due to Dr Mohammad's error.

47. Mr Colman submitted that the question of misconduct, like that of impairment, is a matter for the Tribunal's judgement. He submitted that this is a single error of description, but not of management. Mr Colman submitted that the Tribunal may think as a matter of common sense that what matters more than how the CTG is categogised is how the patient was treated. He submitted that if the misdescription did not adversely affect the treatment, it is a different order of concern than if it had.

48. Mr Colman submitted that this particular failing, in all the circumstances, does not amount to misconduct. He submitted that the word 'opprobrium' as refered to by Mr Taylor, on behalf of the GMC, in his review of the law usually connotes some sort of public disgrace arising from shameful conduct. He submitted that whilst it may be undesirable, it is not shameful for a doctor to make a mistake of this kind. Mr Colman submitted that he makes no submission on misconduct in relation to Patient A and allegation 1d. He submitted that Dr Mohammad recognises that the prescription of methotrexate without a confirmed diagnosis of ectopic pregnancy was a serious and regrettable mistake.

49. Mr Colman submitted that Mr Taylor has described encouraging Patient A to accept methotrexate as the only viable option as 'frankly unforgiveable'. He submitted that it is surprising, though, if that be correct, that there is no allegation in respect of that aspect of the consultation within the charge. He submitted that this was a serious clinical error, but it would be a harsh and remorseless medical world if doctors making such errors in good faith could never be forgiven. Mr Colman submitted that this mistake was made in difficult circumstances. He submitted that Dr Mohammad was covering two wards without junior support. He submitted that there were numerous indications of an ectopic pregancy in the

records and the patient's clinical presentation, that led him to a hasty and over-confident misdiagnosis of an ectopic pregnancy with a risk of imminent rupture. Mr Colman submitted that Dr Mohammad thought that the prescription of methotrexate was in the best interest of his patient

50. Mr Colman submitted that departure from his normally high standards is something that Dr Mohammad deeply regrets and will not forget, especially because of its consequences for his patient. He submitted that the Tribunal can be certain that Dr Mohammad will be markedly cautious in the future to ensure that it is not repeated. He sumitted that Dr Mohammad has done everything he can to learn from it and put in place measures to amend his practice.

51. Mr Colman submitted that this is conduct which is easily remediable, that has been remedied and that it is highly unlikely to be repeated. He submitted that, if the Tribunal finds that allegation 2b does not amount to misconduct, then the Tribunal would be considering allegation 1d as what the GMC term 'a single clinical incident' ('SCI') and those three questions become even more prominent according to the GMC guidance on provisional enquiries. He refered the Tribunal to the *Guidance for decision makers on Provisional enquiries*, Part D, paragraph 37 which states:

> *"The key factor distinguishing SCI and SCC PE is that, although the threshold for a full investigation appears to be met, this will not be the case if we obtain cogent evidence that the doctor has remediated the concerns and it is highly unlikely they will be repeated. Where satisfactory evidence of remediation has been obtained, we can properly conclude that an SCI or SCC represents isolated misconduct on the part of the doctor and the chance of it being repeated is so small that their fitness to practise is not currently impaired. This is based on case law often described as the Cohen principles."*

52. Mr Colman submitted that there is no guidance for FTP Panels on single clinical incidents but the same principle must logically apply. He submitted that if the Tribunal finds that allegation 2b is misconduct, the same can be said of that. Mr Colman submitted that Dr Mohammad has undertaken extensive and targeted remedial education and incorporated that learning into his practice. There has been no repetition and the testimonial evidence and feedback show that he practises safely and is highly valued as a senior clinician.

53. Mr Colman submitted that the submission that the Tribunal can discount Dr Mohammad's remediation in some way because he has been under supervision is a contrary one. He submitted that supervision means that any mistake would be more evident than in

unsupervised practice. It does not mean that errors cannot be made but that they would not escape attention. He submitted that there have been no mistakes and supervision gives the Tribunal more confidence that Dr Mohammad has been practising safely.

54. Mr Colman submitted that all doctors make mistakes. He submitted that neither the public nor the requirements of professional regulation demand inhuman perfection from them. Mr Colman refered the Tribunal to the case *of PSA v GMC & Uppal [2015] EWHC 1304 Admin,* which found that a finding of impairment is not required in the interests of patient safety or by the wider public interest. He submitted that public confidence in the profession can be maintained, by the fact that Dr Mohammad has undergone a rigorous disciplinary assessment of his fitness to practise, resulting in a finding of misconduct on his record

55. Mr Colman submitted that a reasonable and well-informed member of the public would understand that these were mistakes made under pressure, that Dr Mohammad has reflected on his failings and developed good insight into how they occurred, and that he has learnt from them. He submited that Dr Mohammad's practice is not currently impaired.

The Relevant Legal Principles

56. The Legally Qualified Chair and Mr Coleman accepted that the law outlined by Mr Taylor in his submissions was the correct approach to be taken in relation to misconduct and current impairment.

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

58. In approaching the decision, the Tribunal was mindful of the two-stage process to be adopted: first whether the facts as found proved amounted to misconduct and whether the misconduct, if found, was serious and then whether any such misconduct found should lead to a finding of impairment.

59. Misconduct has been described as '*a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances'* and that, *'the standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a medical practitioner in the particular circumstances… The professional misconduct must be serious',* per Lord Clyde in *Roylance v GMC (No.2) [2000] 1 AC 311*

60. The Tribunal must determine whether Dr Mohammad's fitness to practise is impaired today, taking into account Dr Mohammad's conduct at the time of the events, the context of that misconduct and any relevant subsequent factors including whether the misconduct found is remediable, whether it has been remedied and the likelihood of repetition. It should also have regard to the public interest in upholding the reputation of the profession and declaring and upholding standards of conduct for members of the profession.

61. 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 endorsed by the High Court in *CHRE v NMC and Paula Grant [2011] EWHC 297 Admin*. In particular, the Tribunal considered whether its findings of fact showed that Dr Mohammad's fitness to practise is impaired in the sense that he:

> *'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*
>
> *…'*

62. The LQC reminded the Tribunal of the need to take into account the overarching objective which is to protect the public and which includes to:

> *a protect and promote the health, safety and wellbeing of the public;*
> *b promote and maintain public confidence in the medical profession;*
> *c promote and maintain proper professional standards and conduct for the members of the profession.*

The Tribunal's Determination on Impairment

Misconduct

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

amounted to misconduct, and then went on to consider whether the misconduct was serious.

Patient A

Paragraph 1d

64. The Tribunal noted Mr Taylor's submissions in relation to some of the paragraphs of GMP but itself found that the following were engaged:

> *'8 You must keep your professional knowledge and skills up to date.*
>
> *11 You must be familiar with guidelines and developments that affect your work.*
>
> *15 You must provide a good standard of practice and care. If you assess, diagnose or treat patients, you must:*
>
> > *a adequately assess the patient's conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views and values; where necessary, examine the patient.*
> > *b promptly provide or arrange suitable advice, investigations or treatment where necessary.*
>
> *16 In providing clinical care you must:*
>
> > *a prescribe drugs or treatment, including repeat prescriptions, only when you have adequate knowledge of the patient's health and are satisfied that the drugs or treatment serve the patient's needs.*
> > *b provide effective treatments based on the best available evidence.*
> > *c …*
> > *d consult colleagues where appropriate*
> > *e …*
> > *f …*
> > *g…'*

65. The Tribunal considered the expert report of Dr I, dated 23 November 2023:

> *'Whether administering a methotrexate injection was an appropriate treatment plan.*

The NICE guideline (Ectopic pregnancy and miscarriage: diagnosis and initial management) recommends that in situations where a 'high probability' of an ectopic pregnancy is present, a holistic view of the clinical and ultrasound presentation must be considered (see paragraph 4 above). The NICE guidelines also comment further on the appropriateness of Methotrexate use. Excluding an intrauterine pregnancy is an essential criterion prior to considering Methotrexate.

'Methotrexate should only be offered on a first visit when there is a definitive diagnosis of an ectopic pregnancy, and a viable intrauterine pregnancy has been excluded.'

In women with a 'suspicion' or 'probability' (as opposed to 'definitive diagnosis') of ectopic pregnancy an expectant or surgical approach is proposed as these options do not jeopardise a possible intrauterine pregnancy. The local Trust guidelines are also in line with NICE recommendations and further help with decision making by categorising patients into 'good' and 'poor' candidates for medical management of ectopic pregnancy with methotrexate. Based on above, my opinion is that administering a methotrexate injection was not an appropriate treatment plan.'

…

'Seriously below standard

The following aspects of care were seriously below the standard expected of a reasonably competent Consultant Obstetrician and Gynaecologist:

- *…*
- *…*
- *…*
- *Prescribing methotrexate as medical treatment without confirming a diagnosis of ectopic pregnancy'*

66. The Tribunal also had regard to the expert report of Professor K, dated April 2025:

'Performing a diagnostic laparoscopy would have been premature in this case as there was no evidence of free fluid, which is an indication of a leaking ectopic pregnancy and potential blood in the Pouch of Douglas. In the absence of such free fluid, which was definitively excluded by ultrasound scan, then safety netting could have been put into place to monitor the patient's symptoms over the following 48 hours when a repeat beta hCG level should have been carried out. This requires detailed discussion and counselling with the patient and ensuring that the patient understands the reasons for a repeat serial beta hCG level in 48 hours as the scan was not definitive of a viable intrauterine pregnancy, nor was it definitive for an ectopic pregnancy. Therefore, in this uncertainty a conservative approach should have been followed i.e. by measuring

a 48 hours beta hCG level and possibly a repeat scan in 7 days, with a former more likely than the latter. On balance, a 48 hour beta hCG level would have shown a doubling of beta hCG levels.

In my opinion the option for diagnostic laparoscopy was premature and would have on the balance of probabilities been a negative laparoscopy. This would have subjected the patient to having an unnecessary surgical procedure.'

67. The Tribunal accepted the opinions of both experts.

68. The Tribunal did not accept that Dr Mohammad was rushed and that was what resulted in him making this mistake. Although there were less junior staff available on the ward, there were still consultants available. Dr Mohammad had already consulted with another colleague which shows that there were colleagues available and he had the time to seek advice. The Tribunal found that Dr Mohammad also had time to give Patient A the three options, then allowed time for her to deliberate on her decision and come back to him.

69. The Tribunal determined that this conduct in regard to Patient A amounted to serious professional misconduct, as Dr Mohammad actively arranged for the injection to be administered and he should have been aware of the consequences of doing so, if the fetus had been viable. Dr Mohammad's conduct fell very far short of the standards expected and was particularly grave.

Patient B

70. The Tribunal are considering this matter having regard to the wording of the Allegation. Dr Mohammad was not charged with a recording error but he is charged with incorrectly interpretating and classifying that Patient B's CTG as normal.

71. The Tribunal considered paragraphs 8,11 (as set out above) , and 21(a) of GMP to be engaged in this case:

'21 Clinical records should include:
a relevant clinical findings…'

72. The Tribunal had regard to the expert report of Dr J, dated 14 February 2024:

'Returning to the issue to be addressed, it is my opinion that Dr Mohammad did not correctly interpret and classify Patient's CTG when he reviewed it at around 17:10 and his practice at this point fell seriously below the expected standard.'

73. The Tribunal also had regard to the expert report of Professor K, dated April 2025:

'b. incorrectly interpreted and classified the 5 September CTG as normal;

In my opinion, the CTG categorised on 5 September 2022 at around 1710 hours was not normal. This was an antenatal CTG which should have been categorised as being abnormal based on reduced variability of < 5 bpm, with shallow decelerations albeit that this may have been associated with some period like cramps, which were not felt by the midwife.

Overall, in my opinion, the categorisation of the CTG at 1710 hours fell seriously below the expected standard from a consultant obstetrician.'

74. The Tribunal agreed with both experts and held the view that this misconduct was serious. It took the view that Dr Mohammad made a fundamental error in reading the CTG which had the potential to cause serious harm to Patient B's baby.

75. The Tribunal has concluded that Dr Mohammad's conduct fell so far short of the standards of conduct reasonably to be expected of a doctor as to amount to misconduct. The misconduct was serious and can be properly considered to be serious professional misconduct.

Impairment

76. The Tribunal, having determined that Dr Mohammad's conduct amounted to misconduct, went on to consider whether, as a result of that misconduct, his fitness to practise is currently impaired.

77. In determining whether a finding of impairment is necessary, the Tribunal was mindful throughout of the overarching objective and had regard to Dr Mohammad's insight, remediation, and the likelihood of repetition. The Tribunal took the view that Dr Mohammad's misconduct could be remediated as it relates to clinical matters. It was mindful that Dr Mohammad has completed a number of courses, including courses on early pregnancy which is likely to have included learning on ectopic pregnancy. The Tribunal accepted that these courses would have increased Dr Mohammad's knowledge on these

matters. However, it considered that the written reflections received were not sufficient in depth and detail to satisfy the Tribunal that he has remediated.

78. The Tribunal found that Dr Mohammad has shown remorse in relation to Patients A and B and has admitted the relevant paragraphs of the Allegation.

79. The Tribunal did not accept the submissions of Mr Colman that Dr Mohammad's failing, in relation to Patient B, amounted to a recording error and had regard to the wording of the Allegation "incorrectly interpreted and classified the 5 September CTG as normal." However, it acknowledged that the management that followed was what would have been accepted practice if the CTG had been classified as abnormal.

80. The Tribunal took the view that Dr Mohammad has not shown full insight in relation to Patient B as he still maintains his belief that CTG interpretation can be subjective and that his error was in simply recording the CTG as normal when we have expert evidence stating that he should have analysed it in accordance with the guidelines. The Tribunal therefore concluded that there remains a risk of repetition until Dr Mohammad is able to gain insight and remediation of his misconduct in relation to Patients A and B. This would assist in reassuring patients, the public and the profession of the unlikelihood of this misconduct recurring if similar situations presented themselves in the future.

81. The Tribunal had regard to paragraph 76 of the judgment in *CHRE v NMC & Paula Grant [2011] EWHC 927 (Admin),* in which Mrs Justice Cox set out the helpful and comprehensive approach of Dame Janet Smith in her 5th Shipman Report when determining current impairment (see above). The Tribunal determined limbs (a), (b) and (c) were engaged:

> *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 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;*
> *d. … '*

82. The Tribunal was of the view that the misconduct as admitted and found proved was a breach of the fundamental tenets of the medical profession and had brought the profession into disrepute. It had put patients at unwarranted risk of harm. Further, the Tribunal considered Dr Mohammad's misconduct to be damaging to public confidence in the profession.

83. The Tribunal considered that the misconduct admitted and found proved is so serious that a finding of impairment is necessary in order to uphold limbs a, b and c of the Overarching Objective:

> *'a. to protect and promote the health, safety and wellbeing of the public;*
> *b. to promote and maintain public confidence in the medical profession; and*
> *c. to promote and maintain proper professional standards and conduct for members of that profession.'*

84. Taking into account all of the above, the Tribunal therefore determined that Dr Mohammad's fitness to practise is impaired by reason of misconduct.

Determination on Sanction - 22/05/2025

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

The Evidence

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

87. The Tribunal received further evidence on behalf of Dr Mohammad by way of a document containing Dr Mohammad's current IOT Conditions.

Submissions

<u>On behalf of the GMC</u>

88. Mr Taylor, counsel, submitted that the decision as to the appropriate sanction to impose is a matter for the Tribunal exercising its own independent judgment. He stated that the GMC's submission is that the appropriate sanction was one of suspension with a review directed.

89. Mr Taylor referred the Tribunal to the Sanctions Guidance (2024) ('the SG') and the Tribunal's own findings at the previous stages of the hearing. He directed the Tribunal to

paragraphs 4, and 14 to 19 of the SG in relation to the statutory overarching objective and submitted that all three limbs of the overarching objective remain engaged at this stage of the case. Mr Taylor also referred to paragraphs 20 to 22 in regard to proportionality. He submitted that the Tribunal should not give undue weight to whether a doctor has had an interim order and how long the order has been in place. He stated that the fact that Dr Mohammad has been practising under interim conditions is of little significance where the Tribunal concludes that a period of suspension is necessary to protect the public.

90. Mr Taylor directed the Tribunal to the case of *Bolton v Law Society (1994) 1 WLR 512* where the court held that protecting the profession's reputation outweighs a doctor's personal mitigation; hardship to the individual or family, though regrettable, does not render suspension or striking off inappropriate. Membership of the profession brings benefits, but also responsibilities and consequences. Furthermore, Mr Taylor submitted that the tribunal is less able to take mitigating factors into account when the concern is about patient safety or is of a more serious nature than if the concern is about public confidence in the profession.

91. Mr Taylor referred the Tribunal to paragraphs 31 and 32 of the SG in relation to remediation and submitted that the Tribunal, in paragraph 77 of its Determination on the Facts and Impairment, considered that the written reflections received by Dr Mohammad were not sufficient in depth and detail to satisfy the Tribunal that he has remediated.

92. Mr Taylor referred the Tribunal to paragraphs 34, 39 and 40 of the SG in relation to references and testimonials and submitted that the Tribunal should consider what weight, if any, to attach to any testimonials. He also submitted that any references or testimonials will also need to be weighed appropriately against the nature of the facts found proved.

93. Mr Taylor reminded the Tribunal of paragraph 80 of its Determination on the Facts and Impairment in which it considered that '*Dr Mohammad has not shown full insight in relation to Patient B as he still maintains his belief that CTG interpretation can be subjective and that his error was in simply recording the CTG as normal when we have expert evidence stating that he should have analysed it in accordance with the guidelines'*. He submitted that, by the Tribunal's own judgement, remediation and insight are both incomplete which means that there subsequently remains a risk of repetition. In support of this, Mr Taylor reminded the Tribunal of paragraph 80 of its Determination on the Facts and Impairment where it stated that '*there remains a risk of repetition until Dr Mohammad is able to gain insight and remediation of his misconduct in relation to Patients A and B*'.

94. Mr Taylor stated that this is not a rare or exceptional case and taking no action would be wholly inadequate and inappropriate. With regards to conditions, Mr Taylor referred the

Tribunal to paragraphs 81 and 82 of the SG along with paragraph 69 of its Determination on the Facts and Impairment in which it stated, in relation to Patient A: '*Dr Mohammad's conduct fell very far short of the standards expected and was particularly grave'.* In relation to Patient B, the Tribunal stated at paragraphs 74 and 75 of its determination*:' Dr Mohammad made a fundamental error in reading the CTG which had the potential to cause serious harm to Patient B's baby….Dr Mohammad's conduct fell so far short of the standards of conduct reasonably to be expected of a doctor as to amount to…serious professional misconduct'.*

95. Mr Taylor submitted that Dr Mohammad's misconduct is too grave, particularly in terms of the devastating consequences for Patient A, for conditions to be an appropriate or proportionate sanction. He further submitted that Dr Mohammad's insight and remediation remain incomplete, such that there is a risk of repetition, despite the doctor practising recently under interim conditions.

96. Mr Taylor directed the Tribunal to paragraphs 91, 92, 93, 97(a),(e),(f) and (g) of the SG. He submitted that suspension has a deterrent effect and can be used to send out a signal to the doctor, the profession and the public about what is regarded as unacceptable conduct. Mr Taylor stated that whilst the misconduct in this case is so serious that action should be taken to protect members of the public and maintain public confidence in the profession, it is not submitted that Dr Mohammad's conduct is fundamentally incompatible with continued registration. He submitted that, whilst there has been acknowledgement of fault, the Tribunal concluded at paragraph 80 of its Determination on the Facts and Impairment that there remains a risk of repetition.

97. Mr Taylor submitted that the misconduct in this case is not so difficult to remediate that complete removal from the register is in the public interest. However, the departure from Good medical practice is serious enough that a sanction lower than a suspension would not be sufficient to protect the public. He stated that although the Tribunal considered, at paragraph 77 of its Determination on the Facts and Impairment that, *'the written reflections received were not sufficient in depth and detail to satisfy it that Dr Mohammad has remediated,'* he does not submit that there is evidence that demonstrates that remediation is unlikely to be successful. Mr Taylor submitted that there has been no evidence of repetition of similar behaviour since the incidents. He also submitted that there is evidence of insight, albeit limited, and a risk of repetition, although not expressed as significant.

98. In relation to the length of suspension, Mr Taylor referred the Tribunal to paragraphs 99 to 102 of the SG and submitted that the Tribunal should impose a suspension for a period of time that is needed for meaningful and genuine insight to be developed and for full remediation to occur. He submitted that a review should be directed at the end of the

suspension to reassure the reviewing Tribunal that Dr Mohammad is fit to resume practice either unrestricted or with conditions.

99. Mr Taylor submitted that this is not a case in which erasure is required as the only means of protecting the public. He submitted that this is a case where Dr Mohammad did not act in his patients' best interests and he failed to provide an adequate level of care, falling well below expected professional standards. He stated that there was a reckless disregard for patient safety in Patient A's case. Mr Taylor submitted that Dr Mohammad breached the fundamental tenets of the profession and brought the profession into disrepute. He reminded the Tribunal of paragraph 82 of its Determination on the Facts and Impairment where it found that Dr Mohammad's conduct put patients at unwarranted risk of harm. He further submitted that Dr Mohammad has the potential to develop full insight into these failures and so suspension would be sufficient.

100. In summary, Mr Taylor submitted that a period of suspension, with a review directed at the end of the period of suspension, is the appropriate and proportionate sanction in this case.

On behalf of Dr Mohammad

101. Mr Colman, counsel, submitted that the Tribunal has already found at Paragraph 78 of its Determination on the Facts and Impairment that Dr Mohammad's fitness to practice is currently impaired and that he would benefit from reflecting in more depth and detail on his misconduct to gain greater insight. He submitted that this "*would assist in reassuring patients, the public and the profession of the unlikelihood of this misconduct recurring if similar situations presented themselves in the future*." As stated in Paragraph 80 of the Tribunal determination.

102. Mr Colman submitted that an order for conditional registration would allow Dr Mohammad that opportunity to reflect and gain greater insight, while also permitting him to continue providing the excellent and valued service to the people of mid-Wales that he currently does. He submitted that Dr Mohammad started work at Bronglais Hospital as a substantive consultant in November 2022 and he has worked under supervision since 12 June 2024. He stated that there have been no incidents or concerns either before or after the supervision began in those two and a half years.

103. Mr Colman submitted that the Tribunal has already read the testimonial evidence from Dr Mohammad's colleagues. He reminded the Tribunal of Mr C's testimonial which states:

"Dr Mohammad consistently demonstrated strong clinical acumen, a careful and methodical approach to diagnosis, and a genuine commitment to patient care. He was always approachable, respectful, and collegial - a valued member of the clinical team. His communication with patients and colleagues alike was professional and compassionate, and he remained dedicated to his ongoing professional development.

Based on my experience, I believe Dr Mohammad is a capable and conscientious clinician who has much to offer the profession. I hope the Tribunal will consider the wider context of his career and the many positive qualities he brings to his work."

104. Mr Colman also referred the Tribunal to the testimonial of Mr D (Dr Mohammad's supervisor) which described Dr Mohammad's experience and skill:

"… he is a very experienced, very skillful consultant in Obstetrics and Gynaecology and I have no concerns regarding his ability or skill. I would be very happy for him to look after my family as a consultant Obstetrician and Gynaecologist. I fully support him in this case for the GMC and I feel that he is keen, honest, experienced and a competent consultant."

105. Mr Colman reminded the Tribunal of the testimonial provided by Ms C in relation to how Dr Mohammad interacts with patients:

"The patients trust him and I have seen him in difficult situations, when he talks to a patient and her family after a traumatic event: he establishes first respectful and empathic rapport, then he starts by summarizing the facts and manages to make everybody understand what happened. Then he offers treatment options and always listens to the patient's wishes. He is always open to answer questions in detail, in a logic and accessible manner, such as the patient understands completely.

All I can say is that if I would have a health problem, I would want a doctor like Mr. Haleem to treat my disease, as I know that he is knowledgeable, he cares for the patients, he is intelligent and he loves his job."

106. Mr Colman submitted that Dr Mohammad's patients agree. He stated that the Tribunal has seen the feedback which is well above the national average. Mr Colman submitted that Dr Mohammad's patients make comments such as:

"I felt totally at ease, he made me feel able to ask questions. Very happy to see this doctor again."

"We need more doctors like Dr Mohammad Haleem."

"It was a wonderful experience, Mr Haleem explained in detail every step of the procedure. Put my mind at rest."

107. Mr Colman submitted that suspension, as suggested by the GMC, would not serve the public interest in allowing that quality of care to continue. It would be punitive rather than protective. He stated that judging the gravity of the misconduct, the Tribunal's focus should be more on the extent of the failure than on its consequences. Mr Colman stated that Dr Mohammad has practiced safely now for a significant period and there is every indication that he can continue to do so in the same way. He submitted that although Dr Mohammad's employers are generally supportive, suspension could have the drastic effect of terminating his contract. It would, in any event, have serious financial consequences for Dr Mohammad, preventing him from earning his living.

108. Mr Colman submitted that an order of conditional registration could provide additional assurance of patient safety and equally address the public interest in maintaining confidence in the profession and upholding proper standards. He submitted that it would show that appropriate and proportionate regulatory action had been taken and it would not risk him becoming deskilled through suspension.

109. Mr Colman submitted that a reasonable and well-informed member of the public would know that at no point had Dr Mohammad intended to cause any harm to his patients. He submitted that although mistaken and misguided, Dr Mohammad had always thought that he was acting in his patients' best interests. He submitted that the public would understand why an order for conditional registration is a sufficient and proportionate sanction, given the circumstances of this case.

110. Mr Colman submitted that the Tribunal has seen the interim conditions with which Dr Mohammad has been fully compliant and under which he has successfully practiced for nearly a year to assist it in coming to a decision as to the appropriate sanction. He submitted that this shows both that conditions are workable and that they have been effective. Mr Colman submitted that the Tribunal might also want to take that period into account when deciding the duration of any order, to give Dr Mohammad time for the further reflection as it has suggested.

The Tribunal's Determination on Sanction

111. The decision as to the appropriate sanction, if any, to impose is a matter for the Tribunal alone, exercising its own judgement. In reaching its decision, the Tribunal has taken GMP and the SG into account and has, at all times, borne in mind the overarching objective.

112. The Tribunal reminded itself that the main reason for imposing any sanction is to protect the public and that sanctions are not intended to punish doctors, even though they may have a punitive effect. Throughout its deliberations, the Tribunal has applied the principle of proportionality, balancing Dr Mohammad's interests with the public interest.

113. Before considering what action, if any, to take in respect of Dr Mohammad's registration, the Tribunal considered the aggravating and mitigating factors in this case.

Aggravating Factors

114. The Tribunal was unable to establish any specific aggravating factors in this case. It has already taken into account the effect on Patient A of the actions which led to the termination of her pregnancy and the potential harm to Patient B's infant when considering the seriousness of Dr Mohammad's misconduct.

Mitigating Factors

115. The Tribunal considered the following to be mitigating factors in this case:

- Dr Mohammad made full admissions at the outset of the hearing;
- Dr Mohammad has made sincere apologies to those involved in his misconduct;
- Dr Mohammad has completed a wide range of appropriate CPD courses, including courses on fetal heart monitoring and fetal ultrasound;
- The Tribunal has found that Dr Mohammad is on the journey of developing his insight. It bore in mind that he has not yet fully remediated his misconduct;
- The Tribunal has seen a range of testimonials stating that Dr Mohammad is a competent doctor and his contributions are highly valued. The Tribunal has also seen patient feedback of Dr Mohammad from a patient survey, the results of which are well above the national average. It has seen from the feedback that Dr Mohammad is well liked and trusted by his patients;
- The Tribunal considered the lapse of time. The incidents took place in August and September 2022 and there has been no recurrence of similar events as far as the Tribunal is aware;

- Dr Mohammad has cooperated with the inquest in relation to Patient B's infant and he has fully cooperated with the GMC investigation.

116. The Tribunal has taken these factors into account in considering the appropriate sanction under the SG. It considered each sanction in ascending order of severity, starting with the least restrictive.

No action

117. The Tribunal first considered whether to conclude the case by taking no action. Taking no action following a finding of impaired fitness to practise would only be appropriate in exceptional circumstances. The Tribunal determined that given its findings there are no exceptional circumstances in this case and that it would not be sufficient, proportionate, or in the public interest to conclude this case by taking no action.

Conditions

118. The Tribunal next considered whether to impose conditions on Dr Mohammad's registration as proposed by Mr Colman, on behalf of Dr Mohammad. In so doing, it bore in mind that any conditions imposed would need to be appropriate, proportionate, workable, and measurable. The Tribunal took the view that conditions could be imposed that could protect the public but considered whether this would be sufficient.

119. The Tribunal noted that Dr Mohammad did not intend to harm any patients, he believed he was acting in the patient's best interest at the time. It took the view that the aim of the overarching objective, namely maintaining patient safety, protecting patients and upholding proper standards might be achieved through imposing conditions. The Tribunal also considered the lapse of time since the incident and the lack of recurrence and considered that this supported the view that conditions could be appropriate and workable in this case. The Tribunal also bore in mind that Dr Mohammad has been complying with interim conditions for close to a year with no issues.

120. The Tribunal had concerns whether conditions would be sufficient to satisfy the seriousness of Dr Mohammad's misconduct in relation to Patient A where it had found that his conduct fell far below the standards expected of a doctor. Further it had found that it was particularly serious and grave, Dr Mohammad had developing insight, had not fully remediated and there was a risk of repetition of the misconduct.

121. The Tribunal reminded itself of the opinions of Dr I and Dr J which it had accepted. Dr I had opined that in relation to Patient A that Dr Mohammad's action in prescribing Methotrexate fell very seriously below the standard expected of a reasonably competent Consultant in Obstetrics and Gynaecology. Dr J had opined that in regard to Patient B that Dr Mohammad's action in not correctly interpreting and classifying the CTG fell seriously below the standard expected of a reasonably competent Consultant in Obstetrics and Gynaecology. Further, Professor K had concurred that Dr Mohammad's conduct was seriously below the expected standard in relation to both Patient A and Patient B. In the light of its overall findings, the Tribunal determined that it would not be possible to formulate a set of appropriate or workable conditions which would adequately address Dr Mohammad's misconduct. In any event, the Tribunal concluded that a period of conditional registration would not be a sufficient or proportionate sanction to satisfy the public interest, particularly as Dr Mohammad's misconduct amounted to serious departures from GMP.

Suspension

122. The Tribunal next considered whether it would be appropriate and proportionate to suspend Dr Mohammad's registration.

123. The Tribunal considered the SG in relation to suspension including paragraphs 91 and 92, which state:

> *'91. Suspension has a deterrent effect and can be used to send out a signal to the doctor, the profession and public about what is regarded as behaviour unbefitting a registered doctor. Suspension from the medical register also has a punitive effect, in that it prevents the doctor from practising (and therefore from earning a living as a doctor) during the suspension, although this is not its intention.*
>
> *92. Suspension will be an appropriate response to misconduct that is so serious that action must be taken to protect members of the public and maintain public confidence in the profession. A period of suspension will be appropriate for conduct that is serious but falls short of being fundamentally incompatible with continued registration (i.e. for which erasure is more likely to be the appropriate sanction because the tribunal considers that the doctor should not practise again either for public safety reasons or to protect the reputation of the profession).'*

124. The Tribunal recognised that a sanction of suspension does have a deterrent effect and can be used to send a signal to Dr Mohammad, the profession, and the public about what is regarded as behaviour unbefitting a registered doctor. It also acknowledged that

suspension is an appropriate response to misconduct which is serious, and that action is required in order to maintain public confidence in the profession, but which falls short of being fundamentally incompatible with continued registration.

125. The Tribunal also had regard to paragraph 97 of the SG which sets out some of the circumstances in which suspension may be the appropriate sanction. The Tribunal considered a, e, f and g to be engaged in this case:

> *'97 Some or all of the following factors being present (this list is not exhaustive) would indicate suspension may be appropriate.*
>
> *a A serious breach of Good medical practice, but where the doctor's misconduct is not fundamentally incompatible with their continued registration, therefore complete removal from the medical register would not be in the public interest. However, the breach is serious enough that any sanction lower than suspension would not be sufficient to protect the public or maintain confidence in doctors.*
>
> *…*
>
> *e No evidence that demonstrates remediation is unlikely to be successful, e.g. because of previous unsuccessful attempts or a doctor's unwillingness to engage.*
>
> *f No evidence of repetition of similar behaviour since incident.*
>
> *g The tribunal is satisfied the doctor has insight and does not pose a significant risk of repeating behaviour.*

126. The Tribunal was in no doubt that Dr Mohammad's misconduct, particularly in relation to Patient A, was so serious that action is required to protect the public, maintain confidence in the medical profession, and uphold proper professional standards for members of the profession.

Erasure

127. The Tribunal acknowledged that, where there has been a particularly serious departure from the principles set out in GMP and it is satisfied that a doctor's behaviour is fundamentally incompatible with his continuing to be a doctor, it should consider erasure. It

noted in particular that it has found Dr Mohammad's misconduct to be serious and considered this point with great care.

128. However, the Tribunal was satisfied that Dr Mohammad has readily and fully engaged in the regulatory process and that he has taken responsibility for his actions. Further, it was satisfied that Dr Mohammad's apologies and expressions of remorse are wholly genuine. The Tribunal also considered the range of appropriate CPD provided by Dr Mohammad and bore in mind that his level of insight is developing. Also, it has taken into account the testimonials and patient feedback which indicate he is currently a competent doctor. There has been no repetition of Dr Mohammad's misconduct, and the Tribunal was convinced that, with sufficient time allowed, he would be able to fully remediate his misconduct and significantly reduce the risk of repetition.

129. In these circumstances, the Tribunal determined that a sanction of erasure would not be proportionate or appropriate.

The Tribunal's Decision

130. The Tribunal determined a period of suspension to be the appropriate and proportionate sanction to fulfil the overarching objective to protect the public. It considered that a period of suspension would balance Dr Mohammad's interests with the need to send a clear message that his misconduct was wholly unacceptable for a member of the medical profession and that this misconduct is also unacceptable in order to uphold professional standards and public confidence in the profession.

131. In determining the length of the suspension, the Tribunal considered the aggravating factors which are relevant to the length of the suspension, namely the seriousness of the findings including:

- The extent to which the doctor departed from the principles of Good medical practice;
- The extent to which the doctor's actions risked patient safety or public confidence.

132. The Tribunal was satisfied that suspending Dr Mohammad for a period of six months would sufficiently mark his serious misconduct. Further, it would give him sufficient time to further remediate, gain full insight and complete any professional development needed to ensure that his medical knowledge is up to date without the risk of him losing his knowledge and skills.

133. The Tribunal determined that suspending Dr Mohammad for a period of six months is sufficient to satisfy the statutory objective to protect the public, balancing Dr Mohammad's mitigation, considering proportionality and considering the seriousness of his misconduct.

134. The Tribunal determined to direct a review of Dr Mohammad's case. A review hearing will convene shortly before the end of the period of suspension. The Tribunal wishes to clarify that at the review hearing, the onus will be on Dr Mohammad to demonstrate how he has remediated and developed full insight and that he is fit to return to unrestricted practice. It therefore may assist the reviewing Tribunal if Dr Mohammad provides:

- A further reflective statement to include what he has learned and how he has developed his insight;
- Evidence of any further Continuing Professional Development to address his misconduct and to demonstrate that he has kept his medical skills and knowledge up to date;
- Dr Mohammad may also provide any other information that he considers will support his case in showing that he is fit to return to unrestricted practice.

Determination on Immediate Order - 23/05/2025

Submissions

On behalf of the GMC

135. Mr Taylor submitted that an immediate order is necessary to protect members of the public and is in the public interest. Mr Taylor referred the Tribunal to paragraphs 173 and 178 of the SG. He also reminded the Tribunal of its earlier findings that all three limbs of the overarching objective are engaged in this case.

136. Mr Taylor reminded the Tribunal of its finding in its determination on sanction that there remained a risk of repetition until Dr Mohammad is able to gain insight and remediation of his misconduct in relation to Patients A and B.

On behalf of Dr Mohammad

137. Mr Colman submitted that the test for making an immediate order under section 38 of the Medical Act is the same as that for making an interim order under section 41A. He submitted that the Tribunal must be satisfied that it is necessary for the protection of

members of the public or is otherwise in the public interest. It is also well established that the public interest ground "does at least carry some implication of necessity" and that "in the ordinary case at least, necessity is an appropriate yardstick."

138. Mr Colman submitted that there is no need for an immediate order in the public interest. He submitted that the Tribunal's decision to impose a period of 6 months suspension meets the need to uphold public confidence and standards. He submitted that the suspension will serve the public interest equally whenever it starts.

139. Mr Colman submitted that there is no need for an immediate order for public protection. He submitted that Dr Mohammad is already subject to an interim order of conditional registration, which has been shown to be effective in the protection of the public. The wording of Rule 17(2)(p) – that you "*shall consider and announce whether to make an order under section 41A(3) of the Act in respect of any interim order in place in respect of the practitioner*" – is wide enough to allow the Tribunal to leave that order in place. He submitted that Dr Mohammad's interim conditions are due to expire on 11 June 2025 but can be extended by consent.

140. Mr Colman submitted that there are powerful reasons not to make an immediate order. He referred the Tribunal to paragraph 49 of the sanction determination where it decided that a period of 6 months "*is sufficient to satisfy the statutory objective to protect the public" and proportionate "balancing Dr Mohammad's mitigation … and considering the seriousness of his misconduct*." Mr Colman submitted that any longer period would therefore be disproportionate

141. Mr Colman submitted that an immediate order would extend the period of suspension by at least a month. He submitted that this is a significant percentage of the period judged appropriate. In the event of an appeal, an immediate order could potentially double the period of suspension (or more). He submitted that this is both highly undesirable and deeply unfair.

Further submissions in relation to the status of the interim Order

142. Mr Taylor submitted that the Interim order of conditions cannot remain in place because the Tribunal has decided to impose a sanction of Suspension. He accepted the wording of Rule 17(2) (o) and (p) which he said were sequential and that the Tribunal must first decide whether an immediate order should be made under S.38 of the Act before making any decision in relation to the interim order of conditions currently in place.

143. Mr Colman emphasised that the law does not state that the interim order of conditions must be revoked and said that S.41A (3) of the Act uses the word "may" which means that it is a matter for the discretion of the Tribunal. He submitted that the Tribunal should take into account that when deciding whether to make an immediate order of suspension the fact that there is an interim order of conditions in place which would protect the public.

The Legally Qualified Chair's advice

144. The LQC referred the Tribunal to the Sanctions Guidance from paragraphs 172 to 178. She advised that the criteria to consider are set out in paragraph 172 of the Sanctions Guidance. The Tribunal may impose an immediate order (s.38 of the Act) if it determines it is necessary to protect the public, or is otherwise in the public interest, or is in the best interests of the doctor. She accepted that there was an element of necessity in the ground for public interest.

145. She advised that Rules 17 (2)(o) and (p) of the Rules stated as follows:

> "(o) *the Medical Practitioners Tribunal shall receive any further evidence and hear any further submissions from the parties as to whether an order for immediate suspension or immediate conditions should be imposed on the practitioner's registration, before considering and announcing whether it shall impose such an order and its reasons for the decision."*
>
> *" (p) the medical Practitioners Tribunal shall consider and announce whether to make an order under section 41A (3) of the Act in respect of any interim order in place in respect of the practitioner."*

146. She referred to S. 41A (3) of the Act:

> *"Where an interim suspension order or an order for interim conditional registration has been made in relation to any person under any provision of this section (including this sub section), an Interim Orders Tribunal or a Medical Practitioners Tribunal may, subject to subsection (4) below-*
>
> *(a) revoke the order or revoke any condition imposed by the order:*
> *(b) vary any condition imposed on the order; …."*

147. She explained that the word " may "indicated that the tribunal has a discretion and it does not say the Tribunal shall showing it must do something. She explained that section (4) was not relevant as the doctor was present and submissions had been made.

The Tribunals decision

148. In reaching its decision, the Tribunal has exercised its own judgement and has taken account of the principle of proportionality. The Tribunal has borne in mind that it may impose an immediate order where it is satisfied that it is necessary for the protection of members of the public or is otherwise in the public interest or is in the best interests of the practitioner. It has also considered the guidance given in paragraphs 172, 173, and 178 of the SG relating to immediate orders:

> *172 The tribunal may impose an immediate order if it determines that it is necessary to protect members of the public, or is otherwise in the public interest, or is in the best interests of the doctor. The interests of the doctor include avoiding putting them in a position where they may come under pressure from patients, and/or may repeat the misconduct, particularly where this may also put them at risk of committing a criminal offence. Tribunals should balance these factors against other interests of the doctor, which may be to return to work pending the appeal, and against the wider public interest, which may require an immediate order.*
>
> *173 An immediate order might be particularly appropriate in cases where the doctor poses a risk to patient safety. For example, where they have provided poor clinical care or abused a doctor's special position of trust, or where immediate action must be taken to protect public confidence in the medical profession.*
>
> *…*
>
> *178 Having considered the matter, the decision whether to impose an immediate order will be at the discretion of the tribunal based on the facts of each case. The tribunal should consider the seriousness of the matter that led to the substantive direction being made and whether it is appropriate for the doctor to continue in unrestricted practice before the substantive order takes effect.*

149. The Tribunal also had regard to its previous determinations and the submissions made by Mr Taylor and Mr Colman.

150. The Tribunal accepted that there was an interim order in place and that Dr Mohammad had worked without concern under the conditions imposed for nearly a year. It was aware that an interim order is made following a risk assessment as compared to this Tribunal which had had to assess the seriousness of the findings of fact and determine impairment and then what sanction to impose.

151. The Tribunal has decided that all three limbs of the overarching objective were engaged; the misconduct was of such a serious nature that an order of conditions was insufficient and that the sanction it imposed having regard to all the facts and circumstances of the case was one of suspension for 6 months. Further, Dr Mohammad has not fully remediated, nor gained full insight and there was a risk of repetition. The Tribunal judged that the public would not expect a doctor who had such serious findings to resume unrestricted practice before the order of suspension takes effect where there was a risk of repetition, not full insight and further remediation was needed.
The Tribunal considered that in any event, whether it could be left in place or not, that the interim order of conditions would not be a sufficient restriction on Dr Mohammad's practice having regard to the reasons why the Tribunal imposed a sanction of suspension.

152. The Tribunal therefore decided that an immediate order of suspension was required because of the need to protect members of the public and was otherwise in the public interest.

153. Accordingly, the Tribunal determined to impose an immediate order of suspension upon Dr Mohammad's registration.

154. This means that Dr Mohammad's registration will be suspended from today. The substantive direction, as already announced, will take effect 28 days from the date on which written notification of this decision is deemed to have been served, unless an appeal is made in the interim. If an appeal is made, the immediate order will remain in force until the appeal has concluded.

155. The interim order is hereby revoked.

156. That concludes this case.