Meeting of the s40A Panel to consider the case of Mr Michael Cohn

Held on 13 February 2019.

Panel members present

Charlie Massey, Chief Executive (in the Chair)
Colin Melville, Medical Director and Director of Education and Standards
Anthony Omo, General Counsel and Director of Fitness to Practise

In attendance

Jim Percival, Principal Legal Adviser and Deputy General Counsel
Dawn Crook, Senior Legal Adviser
Mark Swindells, Assistant Director, Corporate Directorate (Panel Secretary)

Purpose of this note

1 This meeting note records a summary of the Members' consideration of the relevant decision of the Medical Practitioners Tribunal ('MPT') which considered the Doctor's case ("the decision"), and the Panel's decision on behalf of the General Medical Council as to whether or not to exercise the power to appeal the decision pursuant to section 40A Medical Act 1983.

The relevant decision

2 The Principal Legal Adviser confirmed that the decision was a relevant decision for the purposes of s.40A.

The GMC is a charity registered in England and Wales (1089278) and Scotland (SC037750)

Consideration

3 The Panel considered the record of the MPT's determination and the legal advice in detail.

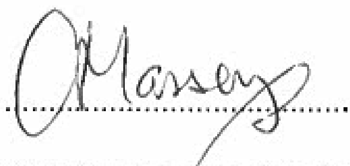
4 The Panel observed that a number of clinical incidents involving Mr Cohn had been investigated by Wye Valley NHS Trust. The nature of these incidents was concerning from a patient safety perspective.

5 The MPT found that some of Mr Cohn's actions amounted to serious misconduct but that his fitness to practise was not impaired. The Panel focussed therefore on whether it was reasonable and allowable for the MPT not to find Mr Cohn impaired in order to protect, promote and maintain the health, safety and wellbeing of the public, and to maintain public confidence in the profession. In this regard, a finding of current impairment was made.

6 In discussion, the Panel found that the MPT had determined that Mr Cohn had shown remediation and insight to the extent that they considered the risk of repetition to be low such that an order of conditions would serve no proper purpose and further that an order of suspension would be disproportionate. The MPT had clearly engaged with the key aspects of the case and the relevant sections of the Sanctions Guidance when deciding to take no action.

7 The Panel concluded therefore that there was no error of principle in the MPT's determination. The Panel therefore concluded that the GMC should not exercise its power to appeal the determination in this case.

8 Because of the nature of the clinical issues involved and the length of time since Mr Cohn has worked without restrictions, the Panel has requested that the GMC's Employer Liaison Service meet with Mr Cohn's Responsible Officer to support the management of his ongoing clinical practise and return to unrestricted practice.



Charlie Massey (Chair)

20/3/19

Dated

Background

9 The Principal Legal Adviser referred to Panel to the details of the case as set out in the MPT's Record of Determination and summarised in the written submission document. The key points to note were as follows:

9.1 This case concerns the determination of a Medical Practitioners Tribunal, which concluded on Thursday 17 January 2019.

9.2 Mr Cohn is a consultant obstetrician and gynaecologist employed by the Wye Valley NHS Trust ('the Trust'). Until April 2015 he was the Trust's Clinical Director. Following a number of clinical incidents involving four patients (B, C, D and E) and a resulting Trust investigation, a local action plan was put in place to allow Mr Cohn to continue to practice, albeit under direct supervision.

9.3 In December 2016, when undertaking his first surgical list under indirect supervision (with the condition for direct supervision having been lifted) Mr Cohn operated on Patient A.

9.4 When concerns were raised about Mr Cohn's treatment of Patient A, a referral was made to the GMC by the Trust in respect of Patients A-E.

9.5 At the hearing before the MPT, Mr Cohn faced the following allegation of misconduct, with the outcome in respect of the factual findings being noted alongside each head of charge for ease of reference:

"That being registered under the Medical Act 1983:

Patient A

1. *On 12 December 2016 you performed an anterior and posterior repair ('First Procedure') and hysterectomy ('Second Procedure') on Patient A and you:*

    a. *failed to adequately consider Patient A's medical and surgical history prior to attending theatre;* ***Admitted and found proved***

    b. *incorrectly assumed Patient A had previously undergone a hysterectomy;* ***Admitted and found proved***

    c. *failed to perform a thorough bimanual examination under anaesthetic (EUA) prior to starting the incision.* ***Determined and found proved***

2. *During the First Procedure you became aware that Patient A had not previously undergone a hysterectomy and you:*

    a. *failed to:*

        i. *adequately communicate with the theatre team and anaesthetist that there would be a major change in procedure from the First Procedure;*

Admitted and found proved

ii. *adequately discuss the risks and benefits of the Second Procedure with the theatre team;* ***Admitted and found proved***

iii. *discuss the change in procedure with your clinical supervisor, Dr B, before proceeding with the Second Procedure;* ***Admitted and found proved***

b. *performed the Second Procedure:*

i. *which was not clinically indicated;* ***Not proved***

ii. *without Patient A's consent.* ***Admitted and found proved***

3. *Following the Second Procedure you failed to:*

~~*a. ensure an incident report was submitted regarding the change in procedure;*~~ ***Removed by amendment under Rule 17(6)***

~~*b.*~~ *a. discuss the complications with your clinical supervisor, Dr B, as required by the restrictions on your practice;* ***Amended under Rule 17(6); Admitted and found proved***

~~*c. record accurately what happened during the procedure by giving the impression you had always intended to perform the second procedure.*~~ ***Removed by amendment under Rule 17(6)***

b. record the unexpected findings that arose during the procedure. ***Amended under Rule 17(6); Admitted and found proved***

Patient B

4. *On 9 June 2015 you performed a laparoscopic bilateral salpingo-oophorectomy, ('First Procedure) and an open laparotomy ('Second Procedure') on Patient B and:*

~~*a. you failed to:*~~

~~*i. recognise that a significant blood vessel in the mesentery had been damaged;*~~ ***Deleted after a successful Rule 17(2)(g) application***

~~*ii. adequately consider whether ligating the vessel would affect the blood supply to the sigmoid colon;*~~ ***Deleted after a successful Rule 17(2)(g) application***

~~*iii. request surgical assistance from a colorectal surgeon;*~~ ***Deleted after a successful Rule 17(2)(g) application***

b. at or around 16:20, following the Second Procedure, concerns were raised regarding Patient B's low blood pressure and a fall in haemoglobin and you ~~failed to~~: **Amended under Rule 17(6)**

i. failed to review Patient B despite requests to do so; **Amended under Rule 17(6); Not proved**

ii. inappropriately gave instructions for Patient B to be transferred to the ward; **Added by amendment under Rule 17(6); Admitted and found proved**

~~ii.~~ iii. failed to request a gynaecology registrar to review Patient B immediately; **Amended under Rule 17(6); Admitted and found proved**

c. you failed to review Patient B in order to explain:

i. what went wrong during the First Procedure; **Not proved**

ii. why the Second Procedure was necessary. **Not proved**

d. you failed to ensure an incident report was submitted regarding the surgical complications. **Determined and found proved**

Patient C

5. On 7 April 2015 you performed a laparoscopy, left ovarian cystectomy ('Procedure') on Patient C and:

a. during the Procedure you:

i. directly injured the sigmoid colon by making a 3-4 cm incision in the wall; **Admitted and found proved**

ii. failed to recognise that you had directly injured the sigmoid colon. **Admitted and found proved**

6. Following the Procedure you failed to:

a. review Patient C post-operatively; **Not proved**

b. ensure an incident report was submitted regarding the surgical complications. **Admitted and found proved**

Patient D

7. On 21 April 2015 you performed a vaginal hysterectomy ('the procedure') on Patient D, and you failed ensure an incident report was submitted when you were aware of Patient D's return to theatre on 1 May 2015 as a result of complications from the procedure. **Admitted and found proved**

Patient E

8. On 25 June 2015 you were involved in the care and treatment of Patient E and:

a. at or around 20:24 hours you ~~prescribed~~ advised Nifedipine be prescribed which was contraindicated in the presence of antepartum haemorrhage; ***Amended under Rule 17(6); Not proved***

~~b. between 20:06 - 20:45 you failed to commence the process of pregnancy termination;~~ ***Deleted after a successful Rule 17(2)(g) application***

c. at or around 23:37 hours you were informed Patient E had a cumulative blood loss of 2000 ml and you failed to:

i. review Patient E in person; ***Not proved***

ii. ensure that a massive obstetric haemorrhage was declared; ***Admitted and found proved***

iii. attend the labour ward to provide support to:

1. midwives; ***Not proved***

2. obstetric registrar. ***Not proved***

d. at or around 03:35 hours on 26 June 2015 you failed to review Patient E in person as requested by the senior midwife. ***Not proved***

~~9. On or after 26 June 2015 you failed to ensure an incident report was submitted regarding the complications which occurred.~~ ***Removed by amendment under Rule 17(6)***

And that your fitness to practise is impaired by reason of your misconduct."

10 In summary, in respect of each patient, the MPT found:

Patient A- Mr Cohn:

failed to adequately consider her medical and surgical history prior to attending theatre;

incorrectly assumed Patient A had previously undergone a hysterectomy;

having become aware during the surgery that Patient A had not had a hysterectomy, failed to communicate with colleagues or his clinical supervisor that there was a change in procedure;

performed a hysterectomy without Patient A's consent.

Patient B- Mr Cohn:

when advised of concerns regarding Patient B's low blood pressure post surgery, inappropriately gave instructions for Patient B to be transferred to the ward;

failed to request a gynaecology registrar to review Patient B immediately;

failed to ensure an incident report was submitted.

Patient C- Mr Cohn:

during a procedure, directly injured Patient C's colon;

failed to recognise that he had directly injured Patient C's colon;

failed to ensure an incident report was submitted.

Patient D- Mr Cohn:

failed to ensure an incident report was submitted following complications from a hysterectomy.

Patient E- Mr Cohn:

having been informed that Patient E had a cumulative blood loss of 2000 ml, failed to ensure that a massive obstetric haemorrhage was declared.

11 The MPT found that the facts proven in relation to Patient A amounted to serious misconduct. The facts found proven in relation to the other patients were found not to amount to serious misconduct, save for the repeated failure, in respect of Patients B, C and D, to submit an incident report, which cumulatively was considered to be serious misconduct.

12 The MPT found that a finding of impairment was not necessary for patient safety reasons, having concluded that Mr Cohn had sufficient insight, and had remediated the misconduct to a degree that meant that the risk of repetition was low.

13 The MPT nonetheless considered that a finding of impairment was necessary to mark the seriousness of the misconduct so as to uphold public confidence and to maintain proper standards in the profession.

14 At the sanction stage however the MPT concluded that the evidence of remediation and insight was sufficient to amount to there being exceptional circumstances that

justified no action being taken. The MPT considered that conditions would serve no proper purpose in light of the remediation already undertaken, and further that suspension would be disproportionate. Accordingly, the MPT decided to take no action in relation to Mr Cohn's registration.

The General Medical Council's power to appeal pursuant to s.40A.

15 With effect from 31 December 2015, the General Medical Council acquired the power to appeal to the High Court (or equivalent courts in Scotland and Northern Ireland where relevant) against relevant decisions of a Medical Practitioners Tribunal ("MPT") if it considers that the decision is not sufficient (whether as to a finding or a penalty or both) for the protection of the public.

16 The basis upon which the GMC will consider whether or not to exercise this power to appeal is described in "Appeals by the GMC pursuant to s.40A of the Medical Act 1983 ("s.40A appeals") – Guidance for Decision-makers" ("the Guidance").

17 Decisions concerning the exercise of the s40A power to appeal were originally delegated by the Council to the Registrar. However, following recommendations from Sir Norman Williams' Review Council agreed that decision-making in prospective appeals involving decisions of Medical Practitioners Tribunals be delegated to a three person Executive Panel comprising: the Chief Executive and Registrar as Chair; the Medical Director and Director of Education and Standards; and the Director of Fitness to Practise (or their nominated Deputies if not available) ("the Panel").

18 As the Guidance makes clear, when considering whether to bring a s.40A appeal in a particular case, it will be necessary to consider the following questions:

18.1 Based on their assessment of all of the information held, and in the particular circumstances of the case, and having regard to the factors set out in the Guidance, does the Panel consider that the MPT's decision is not sufficient to protect the public?

18.2 If the Panel is of the view, on its assessment of all the information held, in the particular circumstances of the case, that there are grounds to consider that the MPT's decision is not sufficient, it will consider whether exercising the power of appeal would further, rather than undermine, the achievement of the over-arching objective.

18.3 If the answer is yes, then the GMC may exercise its power of appeal

18.4 In considering that question the Panel will be required to consider and weigh a number of competing factors (including its assessment of the prospects of success of the appeal, and the nature and importance of the issues which would be aired).