Health Professions Council
Conduct and Competence Committee –22nd November 2006

High Court Decision in the Matter of Mohammed Khokhar

Executive Summary and Recommendations

Introduction

Between 7th and 10th March 2005 and again on 6th May 2005, a panel of the Conduct and Competence Committee heard an allegation regarding the fitness to practise of Mohammed Khokhar, a clinical scientist. The panel found that Dr. Khokhar's fitness to practise was impaired by reason of his lack of competence whilst in the employment of the North West Thames Regional Genetics Service and consequently imposed a suspension order for one year.

Dr. Khokhar appealed this decision to the High Court and the case was considered by the Administrative Court on 11th, 12th and 13th September 2006. The judgment was handed down on 20th October 2006. The case had originally been listed for hearing on 20th June 2006, however Dr. Khokhar requested an adjournment and this was granted.

In broad terms, the grounds of Dr. Khokhar's appeal were as follows:

- that it was inappropriate for the Panel to proceed to determine the issue of fitness to practice on the basis of practical, written and oral tests
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- that in 66 cases prior to suspension from duty the Appellant was able to conduct cytogenetic analysis without error (which thus demonstrates his competence;

- that the assessments considered by the Panel were conducted in breach of the Trust's Capability procedures; and

- there are criticisms of the strength of the evidence with reference to the available expert evidence.

The case was heard in the High Court by way of a re-hearing.

Decision

The Committee is asked to discuss this case

Background information

The powers of the High Court are set out in Article 38 of the Health Professions Order 2001.

Resource implications

None

Financial implications

Original Hearing

Costs of Hearing (including panel, shorthand writer, legal assessor and expert witness) - £25269.55

Legal costs incurred prior to appeal approx £30,000 (including VAT)

Costs of Appeal £54,053.70 (including VAT)

HPC will be seeking to recoup the costs of the appeal and have made written submissions to this effect before the judge. We are awaiting a decision in this matter.

Appendices

Approved Judgment – Mohammad Tariq Khokhar and Health Professions Council – [2006] EWHC 2484 (Admin)

Date of paper

9th November 2006

Neutral Citation Number: [2006] EWHC 2484 (Admin)

Case No: CO/6564/2005

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 20/10/2006

Before :

MR JUSTICE LLOYD JONES

- -

Between :

MUHAMMAD TARIQ KHOKHAR	**Claimant**
- and -	
HEALTH PROFESSIONS COUNCIL	**Defendant**

- -
- -

Mr. David Giles (instructed by **Dr. Khokhar directly**) for the **Appellant**
Mr. Selvaraju Ramasamy (instructed by **Kingsley Napley**) for the **Respondent**

Hearing dates: 11th, 12th and 13th September 2006.

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Approved Judgment

MR. JUSTICE LLOYD JONES:

Introduction

1. This is an appeal by Dr. Muhammad Tariq Khokhar against a decision of a panel of the Conduct and Competence Committee ("the Committee") of the Health Professions Council ("the Council") made on the 6th May 2005. The appeal is brought pursuant to Article 38, The Health Professions Order 2001.

2. Dr. Khokhar is a registered clinical scientist and as such is regulated by the Council. In the proceedings before the Committee it was alleged that Dr. Khokhar's fitness to practise was impaired by reason of lack of competence. These allegations arose out of concerns which came to light when he was in the employment of North West Thames Regional Genetics Service which is part of the North West London Hospitals NHS Trust ("the Trust") from late 2001 onwards.

3. The case was heard by a panel of the Committee on 7 - 10 March 2005 and 6 May 2005 when it delivered its decision. The panel comprised a chairman, a member specialising in genetics and a lay member.

4. In the proceedings before it the Committee considered particulars of allegations made by the Council against Dr. Khokhar. These particulars were specific instances intended by the Council to provide a factual basis on which the Committee might determine the issue of fitness to practise. Other aspects of the case were presented as part of the background. The primary facts alleged in the nineteen particulars were admitted by the Appellant but the Appellant did not admit the particulars to the extent that they consisted of comment or judgments on the primary facts.

5. The Committee heard evidence from Carolyn Campbell, a Principal Cytogeneticist in the North West Thames Regional Genetics Service and Dr. Khokhar's line manager, and from Katie Waters, the Head of Cytogenetics in the North West Thames Regional Genetics Service, on behalf of the Council. It heard evidence from Dr. Khokhar on behalf of the defence. In addition the Committee heard evidence from two expert cytogeneticists. Dr. Teresa Davies, a jointly instructed expert, is a consultant C Grade clinical cytogeneticist and the Director of the Cytogenetics Centre at Southmead Hospital, Bristol. Mr. Gordon Lowther, a further expert instructed on behalf Dr. Khokhar, is a consultant C Grade clinical cytogeneticist and Head of the Department of Cytogenetics in the West of Scotland Regional Genetics Service.

6. On 6 May 2005 the Committee decided that the allegation of impairment was well founded. It held that Dr. Khokhar's fitness to practise as a registered health professional is impaired by reason of his lack of competence. In arriving at this conclusion it held that Particulars 1, 2, 3, 4, 5, 7, 8, 9, 11, 12, 14, 15, 16, 17, 18, and 19 were well founded. It held that Particulars 6, 10 and 13 were not well founded. It determined to suspend Dr. Khokhar's registration for one year and imposed an interim suspension order under Article 31.

The nature of the appeal to the High Court.

7. The powers of this court on appeal are set out in Article 38, The Health Professions Order 2001. They include the power to dismiss the appeal, to allow the appeal and to quash the decision appealed against, the power to substitute for the decision appealed

against any other decision the Committee could have made and the power to remit the case to the Committee to be disposed of in accordance with the directions of the court.

8. Civil Procedure Rules 52.11(1) provides:
"Every appeal will be limited to a review of the decision of the lower court unless –
(a) a practice direction makes different provision for a particular category of appeal; or
(b) the court considers that in the circumstances of an individual appeal it would be in the interests of justice to hold a re-hearing."
Practice Direction 52 PD paragraph 22 is headed "Appeals against decisions affecting the registration of architects and health care professionals". Paragraph 22.3(1) identifies the appeals to which it applies. These include appeals relating to a range of health care professionals. However, an appeal from a decision of the Health Professions Council is not included.

9. Nevertheless, both parties to this appeal have invited me to conclude that in the circumstances of this appeal it would be in the interests of justice to hold a re-hearing. Mr. Ramasamy, on behalf of the Council, drew my attention to ***Ghosh v. General Medical Council*** [2001] 1 WLR 1915 where it was accepted by the Judicial Committee of the Privy Council that either the Disciplinary Committee of the General Medical Council itself had to be an independent and impartial tribunal or, if not, that its processes had to be subject to control by an appellate body with full jurisdiction to reverse its decisions. On behalf of the Council he urged me to conduct the appeal by way of a rehearing so as to protect the interests of Dr. Khokhar by making available the fullest possible powers of review of the decision below. He was supported in this by Mr. Giles on behalf of Dr. Khokhar. In these circumstances, I consider that it would be in the interests of justice to hold a rehearing. Accordingly, I proceed on the basis that I am entitled to substitute my own conclusions for those of the Committee.

The work of a cytogeneticist.

10. The work of a cytogeneticist involves the detection and interpretation of chromosome abnormalities. In the course of genetic analysis cells are examined under a microscope and diagrams of what is observed are produced for the purposes of interpretation. He will apply a score from a standard scale for the quality of the chromosomes being inspected.

11. There are various grades of clinical scientists in the National Health Service. The lowest grade is Grade A, the training grade, which usually lasts for a period of two to three years. Grade B is the career grade which is achieved on gaining the exit qualification from Grade A. Grade C is the highest grade and carries the equivalent status to that of a medical consultant. Within Grade B there are different bandings. In the case of those following the career structure of clinical scientist within the National Health Service it is only when one completes the A grade that one is able to apply for state registration. Registration entitles an individual to use the title "clinical scientist" and to work unsupervised. However, a number of people, including Dr. Khokhar, have been appointed to positions at Grade B without having undertaken the training grade, Grade A, because it is considered that their experience in other areas justifies their state registration and appointment at Grade B.

The particulars alleged against Dr. Khokhar.

12. The particulars of the allegations against Dr. Khokhar before the Committee were as follows:

"Your fitness to practise as a registered health professional is impaired by reason of your lack of competence as a registered health professional whilst in the employ of the North West Thames Regional Genetics Service.

In particular that:

(1) On a date between 29 October 2001 and 2 November 2001 you failed to identify the abnormality t(8;11)(p24.13;p14.2) in a case that was provided to you as an example of an abnormal case.

(2) On a date between 9 October 2001 and 2 November 2001 you failed to identify the abnormality add(6)(q25.3) in a case that was provided to you as an example of an abnormal case.

(3) On 2 November 2001 you failed to detect a marker (47,XY,+mar) in two cells you analysed and a single cell you counted in a case that formed part of your diagnostic workload.

(4) On a date between 5 November 2001 and 15 December 2001 you reported the abnormality inv(9)(q21.2q34.3) as der(9)del(9)(q34)dup(9)(q33q31), a serious misinterpretation as you interpreted an apparently balanced abnormality as being unbalanced.

(5) On a date between 19 November 2001 and 26 November 2001 you failed to detect the abnormality del(7)(p11.2p13) in a test case that you were given and incorrectly identified the abnormality as 7p+. This is an example of a miss and misinterpretation as a result of not identifying which chromosome 7 homologue was normal.

(6) On a date between 26 November 2001 and 3 December 2001 you failed to detect the abnormality inv(4)(q12q25) in a test case that you were given.

(7) On a date between 26 November 2001 and 14 December 2001 you prepared a report on a test case for trisomy 8 which contained irrelevant detail relating to mosaicism; incorrectly stated that the finding was likely to explain the history of miscarriage and requested inappropriate follow up studies.

(8) On 23 November 2001 in an oral assessment covering four areas of the blood module of the A Grade training programme in clinical cytogenetics you exhibited a standard of performance below that to be expected of a State Registered Clinical Scientist.

(9) On 12 December 2001 in an oral assessment covering four areas of the blood module of the A Grade training programme in clinical cytogenetics and a further area concerned with health and safety you exhibited a standard of performance below that to be expected of a State Registered Clinical Scientist.

(10) On a date between 17 December 2001 and 18 January 2002 you failed to detect the abnormality of a distal long arm of a chromosome 10 in a test case that you were given and reported the case as normal.

(11) On a date between 17 December 2001 and 18 January 2002 you failed to detect the abnormality as a dup(22)(q11.2q11.2) in a test case that you were given and incorrectly identified the abnormality

as a del(22)(q11.2q11.2). This is an example of a miss and misinterpretation as a result of not identifying which chromosome 22 homologue was normal.

(12) On a date between 17 December 2001 and 18 January 2002 you recorded an abnormality of a chromosome 22 when in fact it was chromosome 2 in a test case that you were given. This is an example of a miss and the description of an abnormality not present.

(13) On a date between 17 December 2001 and 18 January 2002 you failed to demonstrate an adequate understanding of referral information in order to target an examination of the chromosome 15 in a test case that you were given.

(14) On a date between 17 December 2001 and 18 January 2002 you failed to demonstrate an adequate understanding of referral information in order to target an examination of the chromosome 22 in a test case that you were given.

(15) On a date between 17 December 2001 and 18 January 2002 you prepared a report on a test case for an interstitial duplication of chromosome 22 region 22q11.2. You identified a syndrome not associated with this abnormality erroneously. This was a serious misdiagnosis.

(16) On 7 January 2002 you took and recorded information on the telephone concerning the booking of a prenatal sample which you failed to understand instead of referring the case to a senior scientist.

(17) On 16 April 2002 in an oral assessment covering the areas of molecular cytogenetics; culturing and harvesting of bloods; meiotic origin of aneuploidy and segregation of translocation you exhibited a standard of performance below that to be expected of a State Registered Clinical Scientist.

(18) Between 8 and 28 January 2003 you undertook ten written exercises concerning areas of theoretical knowledge and aspect of service provision of the laboratory in which overall your standard of performance was found to be below that of a State Registered Clinical Scientist.

(19) On 29 January 2003 in an oral assessment covering the processing, analysis and reporting of a range of samples you exhibited a standard of performance below that to be expected of a State Registered Clinical Scientist."

The case against Dr. Khokhar.

13. Dr. Khokhar was appointed to a B Grade clinical cytogeneticist post at the North West London Hospital NHS Trust with effect from the 16th September 2001.

14. His further education had been Government College, Lahore, Pakistan where he was awarded a B.Sc. in 1968, the University of the Punjab where he was awarded an M Sc. in 1970, Surrey University, Guildford where he was awarded a diploma in 1972 and Imperial College London where he was awarded a Ph. D. in radiobiology in 1977. Thereafter he held a number of post-doctoral posts at various institutions in the United Kingdom. Between 1984 and 1996 he was a Molecular Geneticist Non-Clinical Lecturer Grade 1 at the Royal Marsden Hospital, University of London. Between 1997 and 1999 he was employed as a clinical cytogeneticist at the National Centre for

Medical Genetics in Dublin. In 1999 he was appointed a clinical cytogeneticist at Grade B at St. George's Medical School, London. His application for the post at the North West London Hospital NHS Trust stated that he had more than three years experience at Grade B level.

> "I have a substantial record of both service provision and publication in inherited and acquired disorders. These are a result of knowledge and experience gained while working within the cytogenetic fields. In the past I have held a supervisory role for a team working on a cytogenetics project."

15. Mr. Giles, who appears for Dr. Khokhar in this appeal but who did not appear for him before the Committee, points out that at no time in Dr. Khokhar's employment history prior to his joining the Trust in 2001 had his professional competence as a cytogeneticist been called into question.

16. In the normal course of events Carolyn Campbell, Dr. Khokhar's line manager and head of the post-natal department at the laboratory, would have arranged for Dr. Khokhar to undertake a checking test, to enable him to check the work of non registered staff. However, between the 16th September and 12th October 2001 she assessed thirty eight diagnostic cases that Dr. Khokhar had analysed and assessed. Miss Campbell and Miss Katie Waters, Head of Cytogenetics in the North West Thames Regional Genetics Service, concluded that Dr. Khokhar was not ready to undertake the checking test at that time because of concerns that his approach to analysis was not robust. Dr. Khokhar was informed of this on the 12th October and the situation was to be reviewed three weeks later.

17. Miss Campbell gave evidence that during the following two weeks, in the course of discussions in the laboratory concerning specific chromosome abnormalities and in questions raised by Dr. Khokhar while performing booking in checks, the limited depth and breadth of his theoretical knowledge became apparent.

18. During the course of argument before me reference was made to the first sixty six cases which Dr. Khokhar analysed on his arrival at the Trust. To my mind, these provide little support for Dr. Khokhar's case on this appeal. Of these cases sixty four did not contain any abnormal chromosomes. It was this fact which led Dr. Khokhar to ask Miss Campbell for an opportunity to demonstrate his diagnostic skills. One of these sixty six cases did contain a defective chromosome but it was a case of a trisomy 21 in a patient referred with a suspected diagnosis of Downs Syndrome and so was not a challenging analysis. The remaining case in the first sixty six was, it now appears, O1L/2115 which was to become Particular 3.

Particulars 1 and 2.

(1) **On a date between 29 October 2001 and 2 November 2001 you failed to identify the abnormality t(8;11)(p24.13;p14.2) in a case that was provided to you as an example of an abnormal case.**

(2) **On a date between 9 October 2001 and 2 November 2001 you failed to identify the abnormality add(6)(q25.3) in a case that was provided to you as an example of an abnormal case.**

19. On the 25th October 2001 Miss Campbell and Dr. Khokhar agreed that he would undertake A Grade training in prenatal blood modules and it was arranged that he should analyse two cases previously reported as abnormal so that he could demonstrate his diagnostic analytical skills. He carried out these analyses the following week.

    (1) In the first case the reported abnormality was t(8;11)(q24.13;p14.2). At first Dr. Khokhar reported this case orally as a translocation between chromosomes 8 and 21, t(8;21). Miss Campbell told him this was incorrect but confirmed there was an abnormal chromosome 8. He then reported the case as add(8)(q24). i.e. an abnormal chromosome 8 with additional unidentified material. This was also incorrect. The abnormality had been interpreted as unbalanced when in fact the patient carried a balanced reciprocal translocation.

    (2) In the second case the reported abnormality was add(6)(q25.3), i.e. the chromosome 6 distal to that break point q25.3 was missing and additional material of unidentified origin replaced it. It was an unbalanced karyotype. Despite having been told that it was an abnormal case, Dr. Khokhar failed to identify any abnormality at all. He reported it as 46,XX i.e. an apparently normal female karyotype.

20. These two cases eventually constituted Particulars 1 and 2 before the Council.

21. In her oral evidence Miss Campbell accepted that both structured abnormalities were challenging analytically but were cytogenetically visible. It was also Miss Campbell's evidence that had these been real cases there would have been an adverse affect on the clinical management of the individuals concerned.

22. Dr. Davies concluded in the case of Particular 1 that the size of the abnormality was such that she would expect an experienced cytogeneticist to have no difficulty in detecting the abnormality. In the case of Particular 2 she concluded that the abnormality was cytogentically visible and therefore should be detected. Mr. Lowther stated that it was reasonable to expect that the abnormality in Particular 1 should have been detected. However, in the case of Particular 2 he considered that the terminal region of the long arm (q) of chromosome 6 is a notoriously difficult region to analyse as the banding pattern is only discrete with good quality banding and then the bands often appear somewhat grey. During his visit to the Trust's laboratory at the Kennedy Galton Centre it took him some considerable time to identify the abnormality on the slides which were made available to him.

23. The Committee found Particulars 1 and 2 to be well founded. It observed that in both instances Dr. Khokhar had been informed in advance that an abnormality was present but had failed to identify the abnormality when he should have done so at his level of seniority.

24. In this appeal it is submitted on behalf of Dr. Khokhar that the Committee was wrong to reach this conclusion, notwithstanding the fact that it was admitted that the analyses were incorrect, because in both cases it had failed to take account of the fact that the analysis had been only partly completed. In each case only one cell had been analysed

whereas normally three would be analysed. Mr. Lowther, the expert cytogeneticist who gave evidence on behalf of Dr. Khokhar before the Committee, drew attention to this matter. With regard to Particular 1 he stated:

> "From the given QA score (5/6) on the analysis sheet it is reasonable to expect that this abnormality should have been identified. However, a full analysis does not appear to have been performed on this test case and if more than one cell had been fully analysed then the chances of correctly identifying it would have been increased." (Lowther Report p. 3)

Similarly he stated, in relation to Particular 2:

> "The worksheet for this case gives a QA score of 6 which should allow for the identification of this abnormality. However, it would appear again that the diagnosis has been made on just one cell. This would not be usual practice in a diagnostic setting and if a full analysis of three cells had been performed then this would have increased the chances of picking up this abnormality." (Lowther Report p. 5)

Dr. Davies in her evidence to the Committee did not refer to this aspect of these cases.

25. This leads Mr. Giles to submit that in the case of Particulars 1 and 2 Dr. Khokhar did not make a full attempt at analysing the cell and that it may be that he did not appreciate the importance of these analyses. In this regard he draws attention to the fact that Dr. Khokhar did not record on his worksheet the analysis that he gave orally to Miss Campbell. He points to the evidence of Miss Campbell when cross examined in relation to the failure to record the result in Particular 1.

> "He may have noted it on there. He may have just eyeballed the cell and decided that was a karyotype and reported back to me verbally (sic) without completing an analysis of the case. As I did not see the work sheet at an earlier stage of the proceedings, I could not possibly comment on what he had done." (Day 1, p. 112.)

She accepted that the answer was not recorded on the sheet. (Day 1, p. 112.) While accepting that it was conceded before the Committee that Particulars 1 and 2 were incorrect diagnoses, Mr. Giles contends that these were informal, ad hoc analyses simply for the purposes of discussion. Accordingly, he submits, it would be unfair to rely on these analyses as evidence of incompetence.

26. The point, although foreshadowed in the evidence, does not appear to have been developed before the Committee. In the light of Miss Campbell's evidence quoted above, it seems probable that the incorrect diagnoses which give rise to Particulars 1 and 2 were carried out on an informal basis as Mr. Giles suggests. Moreover, it was accepted by Miss Campbell in her evidence that these were not given as test cases because they were given prior to there being any concerns about Dr. Khokhar's analytical abilities. She explained that there were concerns about his approach to analysis and the documentation of his analysis. However, they did not at that time have any concerns about his ability to detect chromosome abnormality because, to their knowledge, he had not missed any chromosome abnormality at that stage. (Day

1, pp. 115-6) Nevertheless, despite the informality of the occasion and the fact that these were not test cases, I consider that Dr. Khokhar would have appreciated the importance of providing correct diagnoses in these cases. The slides were provided to him in response to his request that he be provided with an opportunity to demonstrate his analytical abilities. (Day 1, p. 61) Contrary to the submission of Mr. Giles, this was clearly more than just "having a go".

27. I accept the evidence of Mr. Lowther that the examination of only one cell would not be usual practice in a diagnostic setting and if a full analysis of three cells had been performed then this would have increased the chances of picking up this abnormality. Moreover, it may well have been the case that in these unusual circumstances Dr. Khokhar was not given the opportunity to examine more than one cell in each case. However, Dr. Davies in coming to her conclusions on Particulars 1 and 2 examined not only the same slides but the same cells which Dr. Khokhar had examined. (Davies Report at pp. 10, 11). She found in the case of Particular 1 that a large number of metaphases were present, many of which were of a suitable quality to identify the abnormality. (Davies Report, p. 11) She did not consider the slide in Particular 2 to be of poor quality. (Davies Report, p. 11.) She concluded that an experienced cytogeneticist would have no difficulty in detecting the abnormality in Particular 1 and that the quality of the slide in Particular 2 was sufficient for the identification of that abnormality. Mr. Lowther, on the other hand, did not examine the same slides used by Dr. Khokhar but accepted on the basis of the QA score of 5/6 in Particular 1 that the abnormality in that case was potentially visible and on the basis of the QA score of 6 in Particular 2 that it should have allowed for the identification of the abnormality. (Lowther Report pp. 4, 5.) Moreover, Dr. Khokhar had been told that there were abnormalities in each of these cases.

28. In these circumstances I have come to the conclusion that, despite the relatively informal nature of what occurred and despite the fact that the procedures were not those of a normal analysis, it was not unfair or unreasonable for the Committee to rely on these instances as evidence in support of a lack of competence on the part of Dr. Khokhar.

29. Mr. Giles made a further submission in relation to Particular 2. He drew attention to the evidence of Mr. Lowther as to the difficulty of analysing this region of chromosome 6 and the difficulty encountered by Mr. Lowther himself in identifying this abnormality, to which reference has been made above. He submitted that, as in the case of Particulars 6 and 10, where similar difficulties of analysis were accepted by the Committee, the Committee should have concluded in the case of Particular 2 that the allegation was not established.

30. It is common ground that the abnormality in Particular 2 was a subtle one. Miss Campbell observed in her evidence that the two cases which form Particulars 1 and 2 were provided to enable Dr. Khokhar to prove his analytical ability and therefore they had to be reasonably challenging abnormalities. (Day 1, p. 115) Moreover, in her report Dr. Davies referred to the difficulty of detecting the abnormalities in Particulars 2 and 6 in identical terms, recognising that the chromosome in question had some areas of banding that are less distinct than areas of other chromosomes. (Davies Report pp. 11, 14.) However, Dr. Davies in her oral evidence commented on the

particularly high quality of the slide which Dr. Khokhar had examined in the case of Particular 2:

> "…the quality can affect the ability to detect things and the smaller abnormalities can be more difficult in poor quality cells. But when I looked at the original slide, in my opinion, it was a beautiful preparation, the banding was extremely clear and because it was a subtle one I particularly noted the quality of the preparation." (Day 3, pp. 42-3.)

Taking account of this evidence and the fact that Dr. Khokhar had been told in advance of the presence of a defective chromosome, I consider that the Committee was entitled to come to a different conclusion in Particular 2 from that it reached in Particulars 6 and 10.

31. For these reasons I consider that Particulars 1 and 2 are well founded.

Particular 3.

(3) On 2 November 2001 you failed to detect a marker (47,XY,+mar) in two cells you analysed and a single cell you counted in a case that formed part of your diagnostic workload.

32. On the 2nd November 2001 Dr. Campbell was undertaking a routine check of Dr. Khokhar's diagnostic work when she discovered a misdiagnosis. He had recorded the karyotype as 46,XY, an apparently normal male karyotype. However the cell analysed by Dr. Campbell had a karyotype of 47,XY. It included a marker i.e. a small unidentified chromosome. Miss Campbell then examined three cells which Dr. Khokhar had analysed and saw the marker chromosome to be present in two of the three cells. She then looked at the single cell that Dr. Khokhar had counted in that case as 46,XY and noted that the marker was also present in that cell. Having detected the marker chromosome in four of the five cells which had been used for the analysis of that case Dr. Campbell then undertook a screen to assess what percentage of cells contained the marker chromosome. In total about 70% of the cells contained the marker in one or other of two forms and in about 30% of the cells the ring was absent. Dr. Campbell's evidence was that the marker chromosome was small but visible and present in the majority of cells and this should have ensured that it was detected. Failure to detect this would have meant failing to diagnose the reason for learning difficulties in the patient. The allegation in Particular 3 specifically related to the failure to detect the marker.

33. This was the only mistake relied on in the Particulars before the Committee which was part of the actual diagnostic caseload undertaken by Dr. Khokhar. All of the other errors relied upon as Particulars before the Committee occurred in assessments.

34. The Committee found Particular 3 to be well founded.

35. The misdiagnosis is admitted. However, on behalf of Dr. Khokhar, Mr. Giles draws attention to the fact that this case O1L/2115 was one of the ten cases picked at random by Dr. Davies from the sixty six work sheets relating to the analyses completed by Dr. Khokhar at the outset of his new appointment. In her analysis Dr. Davies identified eleven chromosomes as requiring clearing whereas Dr. Khokhar identified only seven.

This feature of his analysis is not complained of in Particular 3. However, Mr. Giles points to the fact that Dr. Davies did not in her analysis identify the misdiagnosis alleged in Particular 3 nor did she deal with it in her initial report. On this basis he submits that Dr. Davies's evidence does not support any lack of competence on the basis of the allegation in Particular 3.

36. Mr. Ramasamy responds that the misdiagnosis in Particular 3 was confirmed by Dr. Davies at page 5 of her report under the heading "Review of the analytical, nomenclature and interpretative skills – Allegations 1, 2, 3, 4, 5, 6, 10, 11, 12." However an examination of the text shows that she is here addressing the original slides of the 36 abnormal cases analysed by Dr. Khokhar between 5 November and 15 December 2001 as set out in Exhibit CC 10. Particular 3 predates these cases and is not included in Exhibit CC10. Accordingly, I accept the submission that Dr. Davies's evidence does not support the specific allegation made in Particular 3.

37. However, Mr. Lowther does address it. At paragraph 10 of his report he states that he examined this case. He considered that the supernumerary marker was small but one would have expected a clinical scientist to be able to identify its presence, particularly as it was present in approximately 70% of the cells. I consider that Dr. Lowther's evidence does support the allegation in Particular 3 that this misdiagnosis was the result of a lack of competence. Furthermore, I note in this regard that Dr. Lowther was assured by Dr. Khokhar that the slides he examined were the slides which Dr. Khokhar had analysed. It is relevant that Dr. Lowther found little evidence of cell debris on any of the slides to which he had access which if present could have hindered the identification of this abnormality. (Lowther Report, p. 6.) Moreover, in response to specific questions put on behalf of Dr. Khokhar, Dr. Davies also reviewed the original slide and worksheet and concluded that the marker was clearly visible in the cells analysed by Dr. Khokhar. (Davies Report, p. 12.)

38. For these reasons I consider that Particular 3 is well founded.

39. Thereafter two other diagnostic cases were double checked by Miss Campbell and Miss Waters. They generated longer checklists of chromosomes than Dr. Khokhar had noted. Because of the concerns which had arisen as to Dr. Khokhar's competence Miss Waters, Miss Campbell and another colleague decided that no further diagnostic cases should be undertaken by Dr. Khokhar pending a full review and assessment of his analytical skills.

40. Mr. Giles submits, with regard to Particular 3, that it was not open to the Committee to reason from that single failure that competence was lacking. He contended that it might be evidence of negligence in one instance but could not support an allegation of lack of competence. He complains that by 2 November 2001 at the latest the Trust had formed the view that Dr. Khokhar was not performing at the required standard. At that point he was stopped from performing diagnostic duties. I consider that the Trust was justified in taking that step at that time. Whether or not a single error can establish incompetence, I consider that the history of the matter up to that point justified that decision. In this regard I have in mind, in particular, the evidence in relation to the likely incidence of errors of this kind in best practice. Dr. Davies gave evidence that she would expect an individual to have an error rate of one error every two years.

(Day 3, pp. 25-6.) I also have in mind the obligation on the Trust to act to protect members of the public from the potentially serious consequences of such errors.

Particulars 4, 5, 6, and 7.

(4) On a date between 5 November 2001 and 15 December 2001 you reported the abnormality inv(9)(q21.2q34.3) as der(9)del(9)(q34)dup(9)(q33q31), a serious misinterpretation as you interpreted an apparently balanced abnormality as being unbalanced.

(5) On a date between 19 November 2001 and 26 November 2001 you failed to detect the abnormality del(7)(p11.2p13) in a test case that you were given and incorrectly identified the abnormality as 7p+. This is an example of a miss and misinterpretation as a result of not identifying which chromosome 7 homologue was normal.

(6) On a date between 26 November 2001 and 3 December 2001 you failed to detect the abnormality inv(4)(q12q25) in a test case that you were given.

(7) On a date between 26 November 2001 and 14 December 2001 you prepared a report on a test case for trisomy 8 which contained irrelevant detail relating to mosaicism; incorrectly stated that the finding was likely to explain the history of miscarriage and requested inappropriate follow up studies.

41. Dr. Khokhar's duties were reorganised so that he was not undertaking any analytical work. In the review Dr. Khokhar was to be given further cases already tested and already known to be abnormal, in order to allow him to learn and to demonstrate his skills. In addition, training was made available to him at Grade A level. Over a period of five weeks between the 5th November 2001 and the 15th December 2001 Dr. Khokhar was given thirty six test cases. In these cases he made further analytical errors in thirteen of the thirty six cases. In eleven cases the abnormality was not detected. In the remaining two cases there was serious misinterpretation. In addition, there were instances where the wrong ISCN (International System for Chromosome Nomenclature) was used. Three of the thirteen cases were chosen as Particulars 4, 5 and 6 before the Committee.

42. Particular 4 comprised Case 13 where the reported abnormality was inv(9)(q21.2q34.3). This was reported by Dr. Khokhar as der(9)del(9)(q34)dup(9)(q23q31). In this case, therefore, an apparently balanced abnormality was interpreted as being unbalanced. It was alleged that had it been recorded as such it might have affected adversely the clinical management of the patient.

43. Dr. Davies considered that Particular 4 constituted a serious analytical error with potential consequences on patient management. The abnormality in question had been detected in the laboratory during routine analysis.

44. Particular 5 comprised Case 22. The reported abnormality was del(7)(p11.2p13). Dr. Khokhar reported this as 7p+. The wrong chromosome was identified as abnormal. This is an example of a miss and a misinterpretation. On the evidence of this misdiagnosis it was alleged that Dr. Khokhar was unable to identify which chromosome 7 homologue was normal.

45. In the case of Particular 5 Dr. Davis confirmed the abnormality identified by the laboratory scientists to be correct. Dr. Davies considered that Dr. Khokhar correctly identified one area of chromosome 7 as including band 7b13. However, he wrongly identified the normal chromosome as abnormal. In her view this was a serious analytical error.

46. Particular 6 comprised Case 34. The reported abnormality was inv(4)(q12q25). This was reported by Dr. Khokhar as inv(18)(p11.23q12.1). An abnormality involving chromosome 4 was missed and an abnormality involving chromosome 18 was reported by Dr. Khokhar. It was Miss Campbell's evidence that the chromosomes 18 were normal and any difference between homologues was attributable to recognised normal variation.

47. The Committee decided that Particulars 4 and 5 were well founded. However, in cross examination Dr. Campbell agreed that the case in Particular 6 had a banding pattern that was more difficult than some others. The Committee concluded that Particular 6 was not sufficiently well founded to show impairment because of its challenging nature. It considered that the banding pattern made detection of this inversion difficult.

48. Dr. Khokhar had produced written reports in ten of the thirty six cases. There were errors in two of these reports. In one, which formed Particular 7 before the Committee, Dr. Khokhar incorrectly reported that a condition known as mosaicism was likely to explain the patient's history of miscarriage and thereby requested inappropriate follow up. Dr. Davies considered that this revealed a serious lack of basic knowledge and understanding by Dr. Khokhar. (Davies Report p. 16.) Mr. Lowther observed:

> "I would expect someone at grade 11-13 [within Grade B] to be able to have sufficient cytogenetic and clinical knowledge to accurately report a case of trisomy 8. This was not the case in the report drafted by Dr. Khokhar." (Lowther Report p. 9)

49. The Committee found Particular 7 well founded. The Committee considered that a clinical scientist of Dr. Khokhar's standing should not have prepared a report containing irrelevant detail and then compounded that by unnecessarily alarming the patient.

50. On behalf of Dr. Khokhar, Mr. Giles submits that following the misdiagnosis which gave rise to Particular 3, the Trust had formed the view that Dr. Khokhar was not performing his duties to the required standard and should accordingly have followed the Competence Procedure. He maintains that it did not. In particular it is said that it failed to provide counselling. On this basis it is submitted that it was not open to the Respondent regulatory body to rely on Particulars 4-7 in support of its case both as a matter of principle and because the procedural unfairness renders it unreliable. This submission is considered subsequently with other allegations of unfairness.

51. It is further submitted on behalf of Dr. Khokhar that it is inappropriate to rely on test assessments of this kind, in support of an allegation of a lack of competence. This is considered subsequently**.**

52. With regard to Particular 7 the Appellant makes a number of submissions.

(1) Dr. Khokhar submits that although Dr. Davies in her report states that she examined twenty reports which he had written and concluded that overall the standard was poor and that a number were below the standard expected of a State Registered Clinical Cytogeneticist and if issued could have led to inappropriate patient management, her report does not disclose whether Particular 7 was one of those twenty cases. While pages 5 and 6 of her report may provide some support for this submission, it becomes untenable when one considers a later section of her report in which she answers specific questions drafted by Dr. Khokhar's solicitors. At pages 15-16 she makes clear that she has read the report which forms the subject matter of Particular 7 and, after addressing it at length, concludes:

> "This demonstrates a serious lack of basic knowledge and understanding by the Respondent."

(2) In its ruling the Committee found Particular 7 well founded and observed:

> "A clinical scientist of your standing should not have prepared a report containing irrelevant detail and then compounded that by unnecessarily alarming the patient."

It is said on behalf of Dr. Khokhar that there was no evidence that Dr.Khokhar had alarmed any patient. The case, although a real one, was put before Dr. Khokhar as an academic exercise. I accept that no patient was alarmed in this case. Moreover the Committee was aware that this was a test case and that no report was sent out. The conduct of which complaint is made in Particular 7 does not include alarming a patient. It is limited to preparing a report which contained irrelevant material, incorrectly stating that the finding was likely to explain the miscarriage and requesting inappropriate follow up studies. The Committee was referring to the consequences which would follow had such an error been made in a real diagnosis and it was entitled to do so.

(3) Dr. Khokhar maintains that the inclusion of irrelevant material cannot support an allegation of lack of competence. I am unable to accept this submission. The inclusion of irrelevant material is just as capable of misleading the clinician who receives a report as the omission of relevant material.

(4) It is then said that if the report had been written in a real situation it would not have been signed off by the senior cytogeneticist so it is unlikely that any clinical mistake would have followed. However, the fact that the error may have been identified by another scientist has no bearing on whether the original report reveals a lack of competence on the part of its author.

53. Subject to the arguments on unfairness which are considered below, I consider that Particulars 4, 5 and 7 are well founded.

Particulars 8 and 9.

(8) On 23 November 2001 in an oral assessment covering four areas of the blood module of the A Grade training programme in clinical cytogenetics you exhibited a standard of performance below that to be expected of a State Registered Clinical Scientist.

(9) On 12 December 2001 in an oral assessment covering four areas of the blood module of the A Grade training programme in clinical cytogenetics and a further area concerned with health and safety you exhibited a standard of performance below that to be expected of a State Registered Clinical Scientist.

54. In late 2001 it was decided that Dr. Khokhar should be assessed in certain areas. On the 23rd November 2001 an oral assessment at Grade A level was held. It was conducted by Miss Campbell and Mr. Richard Ellis, a cytogeneticist at North West London Hospitals NHS Trust. The assessment covered four areas of theoretical knowledge and its application.

(1) Referral categories, sample prioritisation, selection of tests.
(2) Variant chromosomes.
(3) Syndromes commonly encountered in postnatal blood referrals.
(4) Segregation and ISCN.

Mr. Ellis and Miss Campbell concluded that there was clear evidence of some knowledge in each of the four categories assessed. However, this was considered to be limited. In particular the clinical significance and application of the areas covered was considered to be at a standard below that expected of a Grade A trainee who had completed his training in these modules. The result of this assessment constituted Particular 8 before the Council.

55. As a result of this failure, it was agreed that Dr. Khokhar should be reassessed in the same areas, plus the additional element of health and safety, again at Grade A level. This assessment took place on the 12th December 2001. The assessors were Miss Campbell and Mr. Ellis. They concluded that there was evidence of learning in the areas covered by the assessment. However, in their view it was clear that much of the material was relatively new and, as agreed with Dr. Khokhar, there was a problem with applying his limited knowledge as a clinical scientist. It was felt that in all five areas covered there were deficiencies and the standard was below that expected of a Grade A trainee.

56. The experts were unable to comment on the results of these oral assessments. They did confirm, however, that the questions were appropriate for the exit examination at Grade A.

57. Whether it was appropriate or fair to assess Dr. Khokhar in this way when he had never held a Grade A post is considered later in this judgment.

58. The Committee found Particular 8 to be well founded. It concluded that the oral assessment suggested an unsatisfactory level of knowledge demonstrated by the recorded answers to well constructed questions. The Committee found Particular 9 to be well founded suggesting an unsatisfactory level of knowledge.

59. On this appeal there is no issue as to the accuracy of the results of the assessments. However, Dr. Khokhar complains that the procedures followed were unfair and placed an enormous burden on him with the result that the assessments did not give a true picture of his abilities. He maintains that it would be wrong in principle to allow the Respondent regulatory body to rely on the results in support of allegations of lack of competence. This matter is considered with other allegations of procedural unfairness later in this judgment.

Particulars 10, 11, 12, 13, 14 and 15.

> **(10) On a date between 17 December 2001 and 18 January 2002 you failed to detect the abnormality of a distal long arm of a chromosome 10 in a test case that you were given and reported the case as normal.**
> **(11) On a date between 17 December 2001 and 18 January 2002 you failed to detect the abnormality as a dup(22)(q11.2q11.2) in a test case that you were given and incorrectly identified the abnormality as a del(22)(q11.2q11.2). This is an example of a miss and misinterpretation as a result of not identifying which chromosome 22 homologue was normal.**
> **(12) On a date between 17 December 2001 and 18 January 2002 you recorded an abnormality of a chromosome 22 when in fact it was chromosome 2 in a test case that you were given. This is an example of a miss and the description of an abnormality not present.**
> **(13) On a date between 17 December 2001 and 18 January 2002 you failed to demonstrate an adequate understanding of referral information in order to target an examination of the chromosome 15 in a test case that you were given.**
> **(14) On a date between 17 December 2001 and 18 January 2002 you failed to demonstrate an adequate understanding of referral information in order to target an examination of the chromosome 22 in a test case that you were given.**
> **(15) On a date between 17 December 2001 and 18 January 2002 you prepared a report on a test case for an interstitial duplication of chromosome 22 region 22q11.2. You identified a syndrome not associated with this abnormality erroneously. This was a serious misdiagnosis.**

60. As a result of these failings, the Trust's capability procedures were formally instigated on 14th December 2001. These involve further review and assessment with the aim of providing employees the opportunity to improve their performance to an acceptable level. Dr. Khokhar's analytical skills were assessed over the period from 17th December 2001 to 18th January 2002. He was given a further twenty cases during this period. On 2nd January 2002 there was an interim meeting after Dr. Khokhar had completed ten of those cases. He had made errors in seven of the ten cases. Shortly after that he was moved to the prenatal section for training of 7th January 2002. Twelve of the twenty cases were considered to be analytically challenging. Of those twelve, one of the five normal cases was analysed incorrectly by Dr. Khokhar in that he considered an abnormality to be present in a chromosome which was normal. In

four of the seven abnormal cases the abnormality was missed and in two of the remainder the abnormality was misinterpreted. Only one abnormal case was analysed correctly. For some of the remainder of the 20 cases an adequate understanding of the referral information was required in order to target an examination of a specific chromosome. These included Cases 43 and 45 considered below. The assessment found that the cytogenetic interpretation of these cases by Dr. Khokhar was generally incorrect, as was the ISCN used to describe the karyotype.

61. Case 39 constituted Particular 10 before the Committee. This was reported by Dr. Khokhar as a normal karyotype but it had a deletion of chromosome 10. Miss Campbell's evidence was that if this "miss" had occurred in a real case the opportunity to explain a congenital malformation in the patient would have been lost. She considered that this instance also illustrated a failure on the part of Dr. Khokhar to complete the necessary checks. However, she accepted that, although the abnormality was clearly visible, the cells were not of the best quality. In cross examination she agreed that the original analyst of the sample in Particular 10 required additional information in order to complete the analysis. She pointed out, however, that Dr. Khokhar had missed the abnormality when the original analyst had not.

62. The Committee found that Particular 10 was not sufficiently well founded to show impaired fitness to practise by reason of lack of competence. It considered that the distal long arm of chromosome 10 was a challenging deletion to detect.

63. Case 40 constituted Particular 11 before the Committee. Dr. Khokhar identified a chromosome as a deleted chromosome 22 with a normal chromosome 22 also in the cells. In fact the chromosome he identified as deleted was a normal chromosome and the chromosome that he thought was normal had a duplication. Miss Campbell's evidence was that this was, therefore, an example of a miss and also a misinterpretation.

64. Dr. Davies noted that this case represented two errors, a failure to identify the abnormality and wrongly identifying a normal chromosome as abnormal. She considered that both are serious analytical errors. (Davies Report p. 18) Mr. Lowther, on the other hand, considered that this abnormality would be very difficult to ascertain. (Lowther Report p. 12)

65. The Committee held that Particular 11 was well founded. It observed that, as in the case of Particular 5, Dr. Khokhar had identified the wrong chromosome of the pair as abnormal.

66. Case 57 constituted Particular 12 before the Committee. Dr. Khokhar recorded the abnormality as involving chromosome 22 when in fact it was chromosome 2. Miss Campbell's evidence was that this was an instance which demonstrated a failure on Dr. Khokhar's part to complete checks and that in some cells the checklist was incomplete.

67. Mr. Lowther observed that the deletion juxtaposed two dark bands making the deletion more, rather than less, difficult to spot. (Lowther Report p. 12) Dr. Davies accepted that chromosome 22 has some areas of banding that may be less distinct than

areas of other chromosomes. However, this did not preclude the identification of abnormalities in these regions. She also observed that this represented two errors, identifying a normal chromosome 2 as abnormal and not identifying the abnormal chromosome 22. Both were equally serious analytical errors with potential consequences for the patient and family. (Davies Report pp. 18-19.)

68. The Committee found that Particular 12 was well founded, observing that finding an abnormality where one does not exist is unsatisfactory in someone of Dr. Khokhar's seniority.

69. Case 43 constituted Particular 13 before the Committee. Here the information provided was that the patient had hypotonia and developmental delay. It was the evidence of Miss Campbell that this should have led to a detailed examination by Dr. Khokhar of chromosome 15. In particular he should have identified cells of adequate quality to enable him to identify chromosome band 15q12. In fact it was reported by him as a normal karyotype. Miss Campbell then asked him to undertake a further analysis, having found suitable cells for him, and Dr. Khokhar then made the correct diagnosis. In her oral evidence Miss Campbell accepted that the abnormality was a challenging one but she considered it was cytogenetically visible.

70. The Committee considered that Particular 13 was not well founded. It considered that hypotonia and developmental delay were not sufficiently specific points of information to target an examination of chromosome 15.

71. Case 45 constituted Particular 14 before the Committee. The information provided was that the patient suffered developmental delay and heart defects. Miss Campbell's evidence was that Dr. Khokhar should have undertaken a detailed analysis of chromosome 22 or suggested appropriate supplementary tests. Dr. Khokhar in fact reported the case as normal and the checklist in this case was not complete.

72. The Committee concluded that Particular 14 was well founded. It considered that developmental delay and heart defect which were detailed were specific points of information that should have alerted Dr. Khokhar to target an examination of chromosome 22.

73. Dr. Khokhar was also asked to submit reports on eighteen of the twenty cases. Miss Waters assessed those reports as being of a standard below that required of a State registered cytogeneticist. She found errors, omissions and the inclusion of irrelevant information. None of the reports could have been issued from the laboratory.

74. One of these reports constituted Particular 15 before the Committee. It was Dr. Khokhar's report on Case 40 (Particular 11), written once the karyotype had been established as a duplication rather than a deletion of choromosome 22. In that report he correctly stated that there was a duplication of chromosome 22 and that it was trisomic. However he then went on to state that the duplication of the region 22q11.2 was associated with DiGeorge syndrome. This was incorrect. It is the deletion of that region that can be associated with DiGeorge syndrome. It was Miss Waters's evidence that clinicians might not have identified that error and might have been led as a result to serious misdiagnosis and treatment mismanagement of the patient.

75. The Committee found that Particular 15 was well founded.

76. The overall conclusion of the assessors on the basis of the twenty cases during the formal review period was that the results supported and reinforced the conclusions previously made regarding Dr. Khokhar's analytical and report writing skills. The assessors concluded that it was not safe for him to undertake a diagnostic workload. Moreover, assessment of his oral performance and the abnormal reports had shown that he was not competent in the areas tested and that he was unable to function at the level expected of a Grade B scientist. (Assessment of first formal review period (17/12/2001–18/01/2002.)

77. Both experts considered that the matters in Particulars 13-15 were appropriate to test at A Grade entry level and that this was a fair way to assess a cytogeneticist who had never held a Grade A post. (Davies Report pp. 19-20; Lowther Report pp. 12-13.)

78. With regard to Particular 11, Dr. Khokhar submits that the Committee made no finding. He points to the omission of any finding in relation to Particular 11 in the Notice of Decision and Order. However, the ruling delivered by the Committee on 6 May 2005 does include an express finding that Particular 11 is well founded. Under the heading "Particulars 5 and 11" it states:

> "You identified the wrong chromosome of the pair as abnormal on each occasion."

The Notice of Decision and Order is identical save that the number "11" has been omitted from the heading. This is clearly a typographical error which would have been readily apparent from the following text. There is no substance in this point.

79. With regard to Particulars 11, 12, 14, and 15 Dr. Khokhar also complains of the unfairness of the procedures followed, in particular the failure to implement Stage 1 of the Competence Procedure, and the unfair work load to which he was subjected. This is considered subsequently. Subject to this matter, I consider that Particulars 11, 12, 14 and 15 are well founded.

Particular 16

(16) On 7 January 2002 you took and recorded information on the telephone concerning the booking of a prenatal sample which you failed to understand instead of referring the case to a senior scientist.

80. On 14 January 2002, while working in the pre-natal section, Dr. Khokhar took a telephone call in relation to the booking in of an amniotic fluid sample. It was alleged that the record he made of the call was incomprehensible to a colleague who read it later that day and that when Dr. Khokhar was asked to explain what he had written he was unable to do so. The colleague had to call the referring hospital to clarify the details. This constituted Particular 16 before the Committee.

81. Dr. Davies considered herself unable to comment on this allegation because she did not review the original written record and was not present during the discussions. However, she stated that accurate recording of clinical information and the need to report areas not understood to senior staff are fundamental to the role of a clinical scientist and that failure to do so would be of major concern. (Davies Report, p. 1)

82. In his evidence to the Committee Dr. Khokhar stated that this incident occurred on his first day in the pre-natal section. It was known that he was not experienced in this area. He had been sent there to gain experience. He took the telephone call from a frantically busy nurse who did not want to talk. She spoke very quickly. He heard something like "IUGR", which is in utero growth retardation but he was not sure whether this was what she said. That was what he had said to the management but they would not listen because they were keen to pick up his errors and that was what they did. (Day 4, p. 56.)

83. The Committee found Particular 16 to be well founded. The Committee was satisfied that Dr. Khokhar failed to understand the information he passed on and that this was unsafe practice.

84. On this appeal, it is submitted by the Appellant that this was a minor incident which was never fully investigated by the Trust and cannot seriously be advanced as evidence of incompetence. I am unable to accept this submission. The primary facts were admitted by Dr. Khokhar. This is a matter which goes to Dr. Khokhar's understanding which is fundamental to the issue of his competence. I consider that Particular 16 is well founded.

Further Assessment and Review.

85. On the 15 January 2002 there was a further oral assessment of Dr. Khokhar. It was carried out by Miss Campbell and Mr. Ellis. The assessment covered introductory and blood sample competencies for Dr. Khokhar's first formal review period. The assessors found that he had demonstrated serious deficiencies in his knowledge and serious misunderstandings with regard to procedures. They concluded that his level of competence was below that of an A Grade trainee who had completed these modules.

86. On the 8th February 2002 the first formal review under the Trust Capability Procedure took place. It related to the period of 17th December 2001 to the 18th January 2002. The result of the assessment was that Dr. Khokhar's standards were not those appropriate for state registration as a B Grade scientist. Dr. Khokhar appealed the outcome of the review on 1 March 2002.

87. Between 4th and 15th March 2002 Dr. Khokhar was on sick leave and consequently formal reviews under the Capability Procedure did not take place as arranged.

Particular 17

(17) On 16 April 2002 in an oral assessment covering the areas of molecular cytogenetics; culturing and harvesting of bloods; meiotic origin of aneuploidy and segregation of translocation you exhibited a standard of performance below that to be expected of a State Registered Clinical Scientist.

88. On the 16th April 2002 there was a further assessment at Grade A standard. It was conducted by Mr. Ellis and Miss Campbell. It covered molecular cytogenetics, culturing and harvesting of bloods, meiosis, origin of aneuploidy and segregation of translocation.

89. With regard to molecular cytogenetics, the assessors concluded that there was limited understanding of the laboratory organisation of FISH work, including which staff were involved, the numbers of samples received and the typed referral. Dr. Khokhar was able to describe the type of probes available but could not describe the syndromes for which the Department offers a diagnostics service. There was some evidence of understanding of the procedure of FISH process but this was muddled and possibly confused with other techniques. There was limited understanding of the health and safety issues. Dr. Khokhar had some limited knowledge of FISH analysis but this was below that expected at Grade A level.

90. With regard to culturing and harvesting of blood samples the assessors concluded that there was poor understanding of the cell cycle. Dr. Khokhar was unaware of the possibility of undertaking 24 hour cultures. He was familiar with some of the practical aspects of culturing but was unclear as to the cellular action of some of the regions used. His understanding was below that expected of Grade A level.

91. With regard to meiosis the assessors concluded that the figures quoted were incorrect as they had been learnt from a table without regard to the denominator. Dr. Khokhar was unaware that he had used a figure for the sex chromosome abnormalities which was for male live births and not total live births. The standard was below that expected of a Grade A scientist.

92. With regard to ISCN segregation analysis Dr. Khokhar had described the translocation correctly. However he showed poor understanding of how the translocation would behave at meiosis and the viability of likely segregants. After prompting he described 3:1 segregation but was unclear as to the significance of the outcome. He incorrectly described the findings as coincidental to the referral of recurrent miscarriage.

93. The overall conclusion was that Dr. Khokhar showed poor understanding of the theory of meiosis and mitosis cell cycles. In particular, he had difficulty in describing the consequences of meiosis both in terms of the aetiology of chromosome abnormalities and the consequences of segregation of balanced translocation carriers. The overall performance was below that expected of a scientist of Dr. Khokhar's grade.

94. Both experts considered that the questions asked were appropriate for Grade A exit level. (Lowther Report p. 13; Davies Report p. 20.) Dr Davies added that the areas covered all fall within routine day to day activities of a practising Grade B scientist and she would expect them to be encountered during routine work. (Davies Report p. 20.)

95. The Committee found that Particular 17 was well founded.

96. On this appeal, the submissions of Dr. Khokhar were limited to the unfairness of the procedure followed. This is considered subsequently. Subject to this matter, I consider that Particular 17 is well founded.

Particulars 18 and 19.

(18) Between 8 and 28 January 2003 you undertook ten written exercises concerning areas of theoretical knowledge and aspect of service provision of the laboratory in which overall your standard of performance was found to be below that of a State Registered Clinical Scientist.
(19) On 29 January 2003 in an oral assessment covering the processing, analysis and reporting of a range of samples you exhibited a standard of performance below that to be expected of a State Registered Clinical Scientist.

97. On 30th December 2002 the second stage of the Trust's Capability Procedure, involving practical and written exercises and oral assessments, began. As part of this assessment Dr. Khokhar took ten written exercises between 8th and 28th January 2003. These were marked by Mr. Ellis and evaluated by Miss Campbell. This assessment was again at Grade A standard.

98. Dr. Khokhar's answers in 7 out of the 10 exercises were considered unsatisfactory. The exercises in which his answers were satisfactory were: laboratory structure and services provided, health and safety and sample requirements. The exercises in which his answers were unsatisfactory related to the following areas: possible origins of aneuploidy, principles of lymphocyte and AF culture, polymorphic variants, abnormalities in leukaemics, population screening, clone and clonal development and services offered by FISH Section.

99. The results of these written exercises constituted Particular 18 before the Committee.

100. Both experts considered that the answers were below the standard sufficient to score pass marks at State registration level. (Davies Report p. 21; Lowther Report p. 14.) In response to the question how far below that level the results fell, Mr. Lowther stated:

> "…it would appear that Dr. Khokhar's knowledge and experience is patchy, in that it is acceptable in some areas but certainly below the expected standard in others." (Lowther Report p. 14.)

Dr. Davies considered that the hour allowed for each test was sufficient. She observed:

> "The answers contained inadequate and inaccurate information. This is not related to insufficient time, but reflects insufficient knowledge and/or understanding." (Davies Report p. 21)

101. The Committee determined that Particular 18 was well founded, observing that for a Grade B cytogeneticist, the answers given fell below the standard expected of someone of that seniority.

102. On the 29th January 2003 an oral assessment at Grade A exit level standard was carried out. It was conducted by Mr. Ellis and Miss Campbell. A union representative sat in as an observer. Although an offer was made to video record this assessment this offer was declined by Dr. Khokhar. The assessment followed the format used as the final assessment for Grade A trainee cytogeneticists at the end of their two year training programme. In six of the ten areas assessed Dr. Khokhar's

answers were not satisfactory. The areas in which his answers were unsatisfactory were mosaicism, CATCH-22, prenatal question, AF sample-maternal age, myeloid leukaemia and AF. The results of this assessment constituted Particular 19 before the Committee.

103. Both experts considered that the questions asked were appropriate to test at Grade A entry level and that this was a fair way to assess a cytogeneticist who had not held a Grade A post. (Lowther Report p. 15, Davies Report p. 21.)

104. The Committee found that Particular 19 was well founded. It considered that the questions were fair and relevant. The evidence supported Miss Campbell's conclusions on this oral assessment which the Committee accepted.

105. On this appeal, the submissions of Dr. Khokhar were limited to the unfairness of the procedure followed. This is considered subsequently. Subject to this matter, I consider that Particulars 18 and 19 are well founded.

Further action by the Trust.

106. The assessment made by Mr. Ellis in February 2003 on the practical work undertaken by Dr. Khokhar, which covered slide making, assessing harvests and G banding slides from the harvest, was that the work was inadequate.

107. On the 10th November 2003 the Trust's Panel met to consider the results of the Capability Procedure. The Panel's decision was that Dr. Khokhar should be demoted to Grade A trainee position within the Trust. Dr. Khokhar appealed that decision unsuccessfully. He went on special leave in February 2003 and then on sick leave from February 2004. He returned to work at Grade A level in January 2005 in a post that was laboratory based but did not involve any analysis.

The general conclusions of the experts.

108. The general conclusions of Dr. Davies, the jointly instructed expert, may be summarised as follows:

(1) The questioning of Dr. Khokhar's competence was not the result of a single mistake. These can occur in any laboratory but are rare events. The question of competence arose due to concerns over a broad area and involving a number of errors involving a number of abnormalities over a period of time. These areas included theoretical knowledge and analysis skills.

(2) She agreed with Mr. Lowther that Dr. Khokhar displayed deficiencies which one would not expect at Grade B.

(3) Following her evaluation of the evidence, she fully supported the allegations made by Miss Waters and Miss Campbell regarding Dr. Khokhar's competence as a clinical cytogeneticist.

(4) Dr. Khokhar is not a competent clinical cytogeneticist and is not of the required standard to practise as a State registered clinical scientist in cytogenetics.

109. The general conclusions of Mr. Lowther, the expert called by Dr. Khokhar, may be summarised as follows.

(1) The skill in analysis which Dr. Khokhar displayed with respect to identifying chromosome abnormalities was below that which is acceptable for a clinical cytogeneticist performing diagnostic chromosome analysis on patient samples. However he identifies several mitigating factors.

(a) Despite Dr. Khokhar's long experience "in the field" he only had somewhere between 3.5 to 4 years experience of diagnostic G-banding prior to this appointment.

(b) Dr. Khokhar had never been taught G-band analysis and this knowledge or lack of it has not previously been tested.

(c) Diagnostic chromosome analysis is a highly stressful procedure and to be subjected to it under test conditions can only add to this stress. The diagnostic miss by Dr.Khokhar in Case 01L/2115 (Particular 3) which was not under test conditions is clearly unacceptable but the occasional miss does happen.

(d) The test analyses to which Dr. Khokhar was subjected were in general subtle abnormalities and some were extremely subtle. He appears to have been subjected to these immediately following the missed diagnosis. As any error in diagnostic cytogenetics inevitably shakes the confidence of the individual concerned, it may have been more helpful to start the testing with some more obvious abnormalities and progress to the more challenging in order to re-establish his confidence. What seems to have happened is that this has led to his demoralisation. These abnormalities should however have been identified by a competent clinical cytogeneticist.

(2) There appeared to be a lack of understanding of the clinical relevance of chromosome abnormalities in order accurately to report cases. Mr. Lowther concurred with the laboratory in their assessment of Dr. Khokhar's ability in this area.

(3) The written assessments of Dr. Khokhar displayed a limited theoretical and clinical knowledge base. The answers which Dr. Khokhar gave were borderline for exiting Grade A.

(4) The written evidence of oral assessments appeared to show that the level of questioning was fair and appropriate and consistent with that which would be used in Grade A internal assessment or the final exit assessment.

(5) It would appear that in his previous positions, both in Dublin and in St. George's, neither his analytical or theoretical skills had been formally assessed.

(6) Dr. Khokhar was not given a full induction to the laboratory and its procedures. Although there was no doubt that his analysis skills were lacking a thorough induction to the procedures and protocols of the laboratory may have helped to alleviate some of the problems encountered.

(7) It would seem that the way in which the assessments were conducted may not have supported Dr. Khokhar during a stressful time and the stress may have been a causative factor in misidentification of further test case analyses. The time constraints and the quality of the preparations available could also have contributed to the subsequent errors he made.

(8) However, he concluded that as far as theoretical knowledge was concerned he was convinced that there are deficiencies which one would not expect at this grade of appointment.

Unfairness.

110. Against this background it is necessary to consider whether, notwithstanding the strength of the case against Dr. Khokhar, the "mitigating factors" identified by Mr. Lowther preclude a finding that Dr. Khokhar's fitness to practise is impaired by reason of his lack of competence. On behalf of Dr. Khokhar, Mr. Giles made a number of more general submissions concerning the fairness of the procedures followed by the Trust and the quality of the resulting evidence which may conveniently be considered at this point.

111. Mr. Giles submitted that an assessment of competence should be based on the way in which Dr. Khokhar conducted actual cases and not test cases. He pointed to the fact that the only Particular which relates to an error in practice in a case currently in the laboratory for analysis is Particular 3. I am unable to accept this submission.

(1) Once concerns had arisen as to the diagnostic ability of Dr. Khokhar, it would have been irresponsible of the Trust to permit Dr. Khokhar to continue to perform this role because it would have exposed members of the public to the risk of misdiagnosis and resulting incorrect clinical treatment. Dr. Khokhar's analytical abilities had to be tested. That could only be done by using test cases.

(2) The test cases which he was given were of a similar quality to those on which he would be working in his diagnostic role in the laboratory. The question of the quality of some individual samples was canvassed in evidence and has been considered above.

(3) The testing of Dr. Khokhar inevitably subjected him to the stress of knowing that he was being assessed. That was unavoidable. However, I would expect a professional person to rise to the challenge. There may also have been some compensating reduction in stress as a result of the fact that the diagnosis would not be relied upon clinically.

(4) I am quite unable to accept that the fact that "test cases" were used invalidates the results or makes reliance on them before the Committee in any way unfair. In this regard I also take account of the number of "test cases" analysed, the period over which the

analyses took place and the variety of abnormalities which arose for consideration.

112. In this regard I should point out that the first sixty six cases analysed by Dr. Khokhar after his arrival at the laboratory in the ordinary course of his diagnostic role did include one failure to detect an abnormality. This became Particular 3 and has been considered above. Moreover, as Dr. Khokhar himself accepted at the time, that initial workload did not allow him an opportunity to display an ability to detect abnormalities. The only other abnormality in the first sixty six cases was in a case where the likely diagnosis was strongly indicated by the terms of the reference to the laboratory.

113. Mr. Giles submits that it was wrong in principle that the Council should have permitted the Trust to collect the evidence which was presented to the Committee. I can see no force in this submission.

(1) Allegations of bias made before the Committee have not been pursued on this appeal.

(2) It was inevitable that the Trust should investigate the matter. It took a responsible course in attempting to deal with the matter internally, while at the same time taking steps to protect the public, and then passing the matter on to the Council, as it was professionally obliged to do.

(3) The Council ensured that the quality and standard of the test cases and assessments and the results were independently validated by the jointly appointed expert witness. Dr. Khokhar was engaged in that process by agreeing the appointment of Dr. Davies and by submitting questions to her. A substantial number of those questions related to the standard and fairness of test cases and assessments.

(4) In the event, the test cases and assessments were further validated by Mr. Lowther. There was a very high degree of agreement between the experts.

(5) To the extent that the Committee was persuaded that an individual test case was inappropriate, the resulting Particular was not upheld.

114. Next, Mr. Giles submitted that the case of Dr. Khokhar had not been dealt with by the Trust in accordance with its established procedures, in particular its Capability Policy. On the contrary, he submitted that the Trust in carrying out the various assessments of Dr. Khokhar had acted unfairly and oppressively. Moreover, it is submitted that the Trust failed to take account of the fact that Dr. Khokhar was in poor health during this period: he was suffering from stress induced angina. As a result, it is said, the Respondent should not be permitted to rely on the results of the assessments as evidence in its proceedings and, in any event, the unfairness was such that the results were unreliable and did not represent a fair view of Dr. Khokhar's professional competence.

115. Before the Committee Dr. Khokhar did advance arguments to the effect that he had been treated unfairly by the representatives of the Trust. Moreover, this was essentially the basis of the matters advanced on Dr. Khokhar's behalf by Mr. Lowther as "mitigating factors". Dr. Khokhar gave evidence as to his perception of how he had

been treated and Miss Campbell and Miss Waters were cross examined about these allegations of unfairness.

116. On this appeal it has been suggested on behalf of Dr. Khokhar that it was for the Council to present evidence to show that correct procedures had been complied with and to establish that there was no unfairness or prejudice to Dr. Khokhar as a result. These submissions seem to me to lose sight of the nature of the proceedings. The question for the Committee was whether the fitness of Dr. Khokhar to practise as a clinical cytogeneticist was impaired by reason of lack of competence. The Council presented its case in the form of a series of Particulars, the primary facts of which were admitted by Dr. Khokhar. The Council did, in fact, put in some evidence about the competence procedures and the periods of illness suffered by Dr. Khokhar while this matter was proceeding. However, if Dr. Khokhar wished to challenge the evidence of the results of test cases and assessments on the basis that it had been obtained in unfair circumstances and was therefore not to be relied upon as giving a true picture of his competence, it was for him to present evidence and to develop his case. The ways in which Dr. Khokhar may have been affected by these events is a matter within his knowledge and it was for him to produce evidence on these matters. In fact, he did produce evidence before the Committee in relation to his perception of the unfairness which had occurred and the effect of these matters on his health.

117. One consequence of the fact that issues of unfairness were raised before the Committee is that the Committee was able to take account of these matters in arriving at its decision. In its decision it expressly declined to accept that Dr. Khokhar's workload was particularly excessive or that the standard of testing competence was a subjective one. It is clear from its decision that it did not accept that there had been any unfairness which impinged on the reliability of the evidence before it. With regard to issues of this character, the Committee had an advantage over this court, sitting as an appellate body, in that the Committee heard the evidence of witnesses and was able to observe their demeanour as they gave it. As a result, I consider that it is appropriate to accord a measure of deference to the conclusions of the Committee in this regard. (See the observations of Lord Rodger of Earlsferry in ***Gupta v. General Medical Council*** [2002] 1 WLR 1691 at paragraph 10.) Nevertheless, I am mindful of fact that this is a rehearing and I have given anxious consideration to whether there was any unfairness which makes it wrong for the Council to rely on any of these matters.

118. Mr. Giles draws attention to the Trust's Capability Policy which includes the following provisions:

> "1.3 It is each manager's responsibility to operate the procedure objectively and fairly and ensure that they and their staff know about the Policy and how to use it.
>
> …
>
> 2.4 The Capability Policy shall be applied consistently in relation to all staff in accordance with the Equal Opportunities Policy.

…

4.1 Managers

It is the line manager's responsibility to ensure that employees meet expected standards of performance for their role.

All managers should investigate the reasons for the incapability. This should be done by meeting with the employee to ascertain the key issues and potential contributory factors.

5.0 Procedure for Handling Performance Issues

5.1 Counselling

If the manager has concerns with a member of staff's current level of performance over a period of time, this shall initially be dealt with informally. The manager to whom the employee is accountable should discuss the shortcomings at a counselling session. At this meeting the following should be achieved:

- The manager outlines the shortcomings in performance to the member of staff;
- The manager identifies the required standard of performance;
- The manager and the member of staff explore the possible causes for the shortcomings in performance levels;
- The manager and the member of staff discuss potential remedies e.g. training and development needs;
- The manager and the member of staff agree a plan of action which should include the following;

- agreement on timetable for remedial action to take place;
- training and development plan;
- the frequency of monitoring and the review date.

The employee should be informed that this is the first stage of the Capability Procedure and that a failure to improve could lead to formal action being taken.

A note of the discussions and plan of action should be given to the employee and retained on the employee's personal file and will be reviewed after six months.

This process shall be applied fairly and consistently to all staff."

119. Mr. Giles contends that at the latest by 2 November 2001, when the decision was taken to take Dr. Khokhar off diagnostic work, there were sufficient concerns about the capability of Dr. Khokhar to require the implementation of the informal first stage of the Capability Procedure by providing counselling. He complains that this was not provided. While no formal procedure was instituted at this stage – indeed it was not

implemented until 14 December 2001 - it is far from clear to me that counselling was not provided. I have referred earlier in this judgment to the discussions which took place at this stage between Dr. Khokhar and his line manager, Miss Campbell. I appreciate that Dr. Khokhar did not find her approach sympathetic or helpful. Nevertheless, it seems to me that informal steps were taken by the Trust at an early stage to discuss with Dr. Khokhar the difficulties which were emerging and to address them in an informal way. In any event, I do not consider that any failure to follow the Capability Policy has the effect of invalidating evidence, for which Mr. Giles contends.

120. In the five weeks between 5 November 2001 and 15 December 2001 Dr. Khokhar completed thirty six cases as part of an assessment of his analytical skills. In eleven of these Dr. Khokhar did not detect the abnormalities present. In a further two cases there was a serious misinterpretation of the abnormalities identified. These thirteen cases include the three cases which are Particulars 4, 5 and 6. Mr. Giles complains that in the week commencing 12 November 2001 Dr. Khokhar was required to complete the remainder of the twelve test cases allocated to him in the previous week plus a further six cases. In the week commencing 19 November 2001 he was required to complete six further test cases. At that point he would be tested on the level of his analytical skills and an approach planned for the two following weeks. During this time he was relieved of his clinical diagnostic duties but was required to increase his work in the blood section, involving supervising and participating in more of the slide making activities. Dr. Khokhar points out that during this time he had, in addition, to prepare for oral examinations. The results of the oral assessments carried out on the 23rd November 2001 and the 12th December 2001 constitute Particulars 8 and 9. He complains that the particularly heavy workload to which he was subject at this time means that the results do not give a fair view of his competence.

121. I accept that this was a considerable workload. However, it has to be compared with the normal workload undertaken by Dr.Khokhar when he first arrived at the laboratory; he was then given twelve cases to analyse each week, although he found that burdensome and did not complete the weekly allocation each week. During this five week period between 5 November 2001 and 15 December 2001 he completed an average of seven analyses each week. His work in the blood section is likely to have been less stressful. I do not consider this workload unfair or oppressive nor do I consider that it resulted in an inaccurate view of Dr. Khokhar's abilities.

122. So far as the examinations are concerned, Mr. Giles on behalf of Dr. Khokhar accepts that the examinations were to be conducted at Grade A i.e. at a grade below that at which Dr. Khokhar had been appointed. However, Mr. Giles points to the fact that Dr. Khokhar had never undergone Grade A training, a course of formal training lasting at least 2 years. Mr. Giles complains that even the parts which Dr. Khokhar was required to study for the purposes of these oral assessments would have taken 2 to 3 months to complete in a Grade A training course. He also points to the fact Dr. Khokhar had never been required by the Council to undergo a Grade A training course and submits that, therefore, the Council cannot rely on Dr. Khokhar's poor performance in examinations they have never, as part of their regulatory function, required him to sit for the purposes of obtaining or retaining state registration.

123. The experts were asked whether these oral assessments were a fair means of assessing a cytogeneticist who had never held a Grade A post. Dr Davies considered that they were. She observed that with his extensive experience in education at various levels and in teaching and training she would not expect oral or written assessments of this kind to present any difficulty to Dr. Khokhar. She noted that the second assessment was a repeat of the areas covered in the first. The first assessment would have given guidance to Dr. Khokhar. (Davies Report, p. 16) She considered that, despite the fact that he had not been a Grade A trainee, she would have expected him to have attained an equivalent standard of knowledge. Mr. Lowther considered that whether a cytogeneticist had come through Grade A or not this would seem an appropriate and fair way to assess his core knowledge. He added:

> "It is interesting to note that the second of the two assessments … contains many of the same type of questions and covered substantially the same information as did the first assessment and that no substantial improvement in the answering or understanding appears to have been made between the two." (Lowther Report, p. 10)

124. I consider that there was nothing unfair in assessing Dr. Khokhar in this way.

125. However, I do consider that there is some substance in the complaint made by Dr. Khokhar in his evidence before the Committee that the health and safety content of the second oral assessment included questions about the conduct of the laboratory which he had joined only comparatively recently and when his induction training had not addressed all relevant procedures. However, this is one limited aspect of the areas covered by the assessments and does not invalidate the overall conclusions which were drawn on the basis of these assessments.

126. Dr. Khokhar makes further submissions on unfairness in relation to Particulars 11, 12, 14 and 15. First he points to the fact that the Trust implemented its Capability Procedure on 14 December 2001. However, he complains that it did not comply with it. In the absence of any evidence on the point it is submitted that it is unlikely that the Trust provided him with any counselling. While I accept that Dr. Khokhar is likely to have been demoralised at this point, there is no evidential basis on which I can conclude that any failure to comply with the Capability Procedure invalidates the results of these test cases. Secondly, Dr. Khokhar complains about the unfair work load to which he was subjected this time. Dr. Khokhar had been given a further twenty cases to complete. The memorandum of 2 January 2002 shows that by that date he had completed ten cases since 17 December 2001, a period of approximately ten working days. On 2 January he was given a further ten cases, four of which were to be completed by 4.00 pm the next day. However, he was not required to prepare reports on those four cases until after they had been assessed by Miss Campbell. In all the circumstances I do not consider this to be such an onerous workload as to make it unfair to rely on the errors of assessment which occurred.

127. Mr. Giles advances further arguments of unfairness in relation to the oral assessment which took place on 16 April 2002 and which eventually formed particular 17. He says that this was intended to be an informal assessment and not part of the formal capability procedure. There is no evidence that Dr. Khokhar was given any notice of this or informed of what the subject matter would be. Furthermore, there

was evidence before the Committee that at this time he had just returned to work after a period of sick leave. In these circumstances, it is said, his poor performance cannot fairly be relied upon.

128. There is no evidence that this was ever intended to be an informal assessment. I accept that by this time Dr. Khokhar had been unwell, suffering from angina induced by stress. No doubt, the position in which he found himself and the live issue as to his professional competence can only have contributed to that stress. However, following a period of sick leave for eleven days he returned to work on 15 March 2002. I do not consider it unfair to conduct an oral assessment on 16 April 2002, a month after he had returned to work, or to rely on the results of that assessment.

129. Similar arguments are advanced in relation to the written and oral assessments which took place between 8 and 28 January 2003 and on 29 January 2003 which constitute particulars 18 and 19. Mr. Giles makes two points here. First he says that there is no evidence that Dr. Khokhar was given any warning of the assessments or any indication of their content. Secondly he points to the state of health of Dr. Khokhar who was absent from work through sickness for a total of ninety eight days between 4 March 2002 and 29 October 2002. He contends that at this stage Dr. Khokhar was under great stress and was being put upon by the Trust in a most oppressive manner.

130. There is simply no evidence about what Dr. Khokhar was told or was not told in advance of the assessments. However, there is in evidence a document which comprises a schedule for this second stage of the Capability Procedure and which shows the exercises contemplated. That is CC26. Moreover, the ten exercises which became Particular 18 were to take about 1 hour each day between 3.30 p.m. and 4.30 p.m.

131. So far as Dr. Khokhar's state of health is concerned, the evidence before the Committee was that he had been back at work since 7 November 2001, following an absence on sick leave since 28 October 2001. Once again, I do not consider that there was any unfairness in the circumstances in which these assessments were conducted which makes the results unreliable or their use unfair. Moreover, I note in this regard that Dr. Khokhar in his evidence expressly denied any suggestion that his prolonged absences from work might have affected his ability to function as a clinical cytologist. (Day 4, p. 69.)

132. Accordingly, for these reasons I have come to the conclusion that there was no unfairness in the treatment of Dr. Khokhar such as to call into question the reliability of the evidence put forward under the various Particulars as an indication of his true professional competence or to make reliance on such evidence unfair.

General conclusions.

133. Notwithstanding the mitigating factors identified by Mr. Lowther, I am entirely satisfied for the reasons set out above that the evidence clearly establishes that Dr. Khokhar's fitness to practise as a clinical cytogeneticist is impaired by reason of his lack of competence.

134. This emerges with great clarity from the expert evidence. This conclusion is expressed very forcefully by Dr. Davies, the jointly instructed expert. I find particularly telling the very considerable extent to which Mr. Lowther, the expert called on behalf of Dr. Khokhar, agrees with many of the conclusions of Dr. Davies and accepts the repeated failure of Dr. Khokhar to attain the professional standards properly expected of a State registered cytogeneticist. I also note the fact that during the course of his oral evidence Mr. Lowther expressly declined to express an opinion on the professional competence of Dr. Khokhar. (Day 4, pp. 171-4.)

135. As Dr. Davies observed in the conclusion to her supplemental report (Davies Supplemental Report pp. 5-6), the question of Dr. Khokhar's competence is not the result of a single mistake. In this field, mistakes of analysis can occur in laboratories but are rare events. The Particulars demonstrate a substantial number of failures to identify abnormalities and misinterpretations. The errors were over a broad area, concerning different topics and over a considerable period of time. It is clear from the evidence before the Committee that these were serious errors. Moreover, the assessments revealed a serious lack of knowledge. The evidence before the Committee establishes, to my mind, an overwhelming case that Dr. Khokhar's fitness to practise was impaired by reason of lack of competence.

Sanctions

136. The sanction imposed by the Committee was suspension from practice for one year. The Committee observed that Dr. Khokhar may wish to use this period to enhance and consolidate his practice and his identified shortcomings by further training and supervision.

137. No submissions have been addressed to me on this appeal in relation to the sanction imposed. I consider that it was entirely appropriate.

Conclusion.

138. For these reasons the appeal is dismissed.