FITNESS TO PRACTISE PANEL
24 NOVEMBER TO 4 DECEMBER 2008
20 TO 30 OCTOBER 2009
7th Floor, St James's Buildings, 79 Oxford Street, Manchester, M1 6FQ

Name of Respondent Doctor:	Dr Jarlath Michael O'Donohoe
Registered Qualifications:	MB BCh 1978 National University of Ireland
Area of Registered Address:	Enniskillen
Reference Number:	2635147
Type of Case:	New case considered by a Fitness to Practise Panel applying the General Medical Council Preliminary Proceedings Committee and Professional Conduct Committee (Procedure Rules) 1988
Panel Members:	Mr A Reid, Chairman (Lay) Ms J Julien (Lay) Dr D Sinclair (Medical) Dr R Smith (Medical)
Legal Assessor:	Mr D Smith
Secretary to the Panel:	Miss D Magill

Representation:
Mr Nigel Grundy, Counsel, instructed by Field Fisher Waterhouse Solicitors represented the GMC.

Dr O'Donohoe was present and represented by Ms Mary O'Rourke, Counsel, instructed by Arthur Cox Solicitors (24 November to 4 December 2008)

Dr O'Donohoe was present and represented by Ms Alison Foster, QC, instructed by Arthur Cox Solicitors (20 to 30 October 2009). Ms Foster did not attend on 20 October 2009.

EXCLUSION OF PRESS AND PUBLIC

The Panel passed a resolution, under Rule 48(2)(b) of the General Medical Council Preliminary Proceedings Committee and Professional Conduct Committee (Procedure Rules) 1988, that the public be excluded from those parts of the hearing where they considered that it would be in the interests of justice or desirable having regard to the nature of the case or the evidence to be given.

CHARGE

"That being registered under the Medical Act;

1. On 12 April 2000 you were employed as a Consultant Paediatrician at the Erne Hospital, Enniskillen; **Admitted and Found Proved**

2. ~~At approximately 10.30 pm~~ You attended, assessed and inserted an intravenous line in to Patient A and in so doing you did not **Admitted and Found Proved**

    a. make an adequate assessment of the condition of Patient A, **Not guilty of serious professional misconduct following an application made under Rule 27(1)(e)(i)**

    b. calculate an acceptable plan of fluid replacement, **Found Proved**

    c. ensure that a record was made on 12 April 2000 of your

        i assessment and diagnosis, **Admitted and Found Proved**

        ii management plan, including a fluid management plan, **Admitted and Found Proved**

        iii calculation of fluid replacement requirements, **Admitted and Found Proved**

        iv fluid prescription stating the identity of the fluid and the rate of infusion over time; **Admitted and Found Proved**

    d. ensure that the nursing staff upon the ward knew of an adequate

        i. fluid replacement plan, **Found Proved**

        ii. system of monitoring its progress; **Found Proved**

    e. monitor or check Patient A again prior to a crash call at about 3 am, **Admitted and Found Proved**

3. You instructed Staff Nurse C to administer a solution

    a. of 0.18% sodium chloride / 4% dextrose, **Admitted and Found Proved**

    b. at a rate of 100 mls per hour until Patient A had passed urine; **Not Found Proved**

4. On 14 April 2000 you made a record of what your fluid management plan for Patient A on 12 April 2000 had been, as being

a. a bolus of 100 mls over 1 hour, **Found Proved**

b. followed by 0.18% sodium chloride/4% dextrose at 30 mls per hour; **Found Proved**

5. Your record was

a. inaccurate, **Found Proved**

b. misleading, **Found Proved**

c. dishonest; **Not Found Proved**

6. The fluid regime set out at paragraph 4 above was

a. not communicated properly by you to those administering the fluid, **Found Proved**

b. not monitored or checked by you to ensure that it was followed, **Admitted and Found Proved**

c. not appropriate in any event; **Found Proved**

7. Your actions or omissions as described at paragraphs 2, 3, 4, 5 and 6 above were

a. not in Patient A's best interests,
Found proved in relation to heads 2(b), 2(c)(i), 2(c)(ii), 2(c)(iii), 2(c)(iv), 2(d)(i), 2(d)(ii), 2(e), 4(a), 4(b), 5(a), 5(b), 6(a), 6(b) and 6(c).

b. below the standard to be expected of a reasonably competent Consultant Paediatrician;
Found proved in relation to heads 2(b), 2(c)(i), 2(c)(ii), 2(c)(iii), 2(c)(iv), 2(d)(i), 2(d)(ii), 2(e), 4(a), 4(b), 5(a), 5(b), 6(a), 6(b) and 6(c).

And that in relation to the facts alleged you have been guilty of serious professional misconduct." **Guilty of serious professional misconduct**

Determination on facts

Dr O'Donohoe

The Panel has considered your case in accordance with the General Medical Council Preliminary Proceedings and Professional Conduct Committee (Procedure Rules) 1988. It has considered all the evidence adduced in this case. It has also taken into account the submissions made by both Counsel.

At the outset you made the following admissions:

Head of charge 1, the stem of head 2 (as amended), 2(c)(i), (ii), (iii), (iv), 2(e), 3(a) and 6(b).

These were announced as found proved.

Following a successful application made in accordance with Rule 27(1)(e)(i), the Panel determined and announced that you are not guilty of serious professional misconduct in relation to head of charge 2(a).

The Panel has considered each of the remaining facts in dispute separately. It has accepted the advice of the Legal Assessor that, when reaching its findings, the burden of proving each of the facts in dispute lies with the GMC and, as previously ruled, the standard of proof is the criminal standard, namely, beyond reasonable doubt.

In relation to the allegation of dishonesty, the Legal Assessor advised that, in determining whether the GMC has proved that you were acting dishonestly, the Panel must first of all decide, whether according to the ordinary standards of reasonable and honest people what was done was dishonest. If it was not dishonest by those standards, that is the end of the matter and the case against you fails. If it was dishonest by those standards, then the Panel must consider whether you yourself must have realised that what you were doing was, by those standards, dishonest.

In relation to your being of good character, the Legal Assessor advised that good character cannot, by itself, provide a defence to a criminal charge, but that it is evidence which the Panel should take into account in your favour in the following ways:

- Your good character supports your credibility. This means it is a factor which the Panel should take into account when deciding whether it believes your evidence.

- The fact that you are of good character may mean that you are less likely, than otherwise might be the case, to act in the way alleged.

In relation to serious professional misconduct, the Legal Assessor referred the Panel to the case of Preiss v General Dental Council (Privy Council Appeal No. 63 of 2000) in which Lord Cooke of Thorndon stated:

> "It is settled that serious professional misconduct does not require moral turpitude. Gross professional negligence can fall within it. Something more is required than a degree of negligence enough to

> give rise to civil liability but not calling for the opprobrium that inevitably attaches to the disciplinary offence"

He also referred the Panel to the case of Silver v General Medical Council (Privy Council Appeal No. 66 of 2002) in which Sir Philip Otton stated:

> "In the instant case there can be little doubt that there was negligence and that it was open to the Committee to find that this constituted professional misconduct. However the Committee should have gone on to consider as a separate issue whether this amounted to serious professional misconduct. It is by no means self-evident that if this question had been posed it would have been answered in the affirmative. It was relevant to consider that this was an isolated incident relating to one patient (albeit over a number of days) as compared with a number of patients over a longer period of time."

Having accepted the advice of the Legal Assessor, the Panel made the following findings:

Head 2(b) has been found proved.

> The Panel accepts the evidence of Dr B, the GMC expert witness, and is satisfied, so that it is sure, that there was not an acceptable plan of fluid replacement.

Heads 2(d)(i) and (ii) have been found proved.

> The Panel has found, at head of charge 2(b), that you did not calculate an acceptable plan of fluid replacement. Therefore, it finds that your plan was not adequate. The Panel also considered the wording of the head of charge which includes "you did not **ensure**" [Panel emphasis] and apart from giving your instructions orally to the nursing staff, you did not do anything else such as writing down your instructions or checking that they had correctly heard and understood your words. For this reason the Panel is satisfied, so that it is sure, that you did not ensure that the nursing staff on the ward knew of an adequate fluid replacement plan. The fluid balance chart and prescription were signed off when they were incomplete. Neither included the rate of infusion over time. You failed to discharge your duty to ensure that the note was complete by your failure to check it. Consequently, you failed to ensure that the staff on the ward knew of an adequate system of monitoring the fluid replacement plan.
>
> Whilst accepting that no head of charge specifically relates to the following, the Panel was shocked by your admission that you were not aware of fundamental work procedures on a ward on which you had been a Consultant for three years. You told the Panel, for example, that you had not been aware that there was no "named nurse" system of patient care. Your approach to and lack of knowledge of the procedures on your ward is illustrated by your own evidence:

"If people are working in a way that you have no experience of, you have not been told about and you have no way of identifying, then you can use the word "team" if you wish, but it is a strange use of the word "team" if one part of the team is doing things their own particular way and you have no way of knowing what that way is. Teamwork does involve communication and that should be both ways. It should not be a matter of me communicating with nurses, if I can put it like – that is part of the issue – but, if there has not been communication in the other direction, then I am not in a position to know where the weak points in the system might be, where things that I think are well thought out do not fit in with everything else that is going on."

The Panel does not accept this view. You had a responsibility to ensure that you did understand the work practices and procedures on your ward. In this, you clearly failed. This lack of engagement on your part placed you in a position which has resulted in your appearance before this Panel today.

Head 3(b) has been found not proved.

The Panel takes the view that Nurse C was a truthful witness and, in giving her evidence, she was attempting to provide the Panel with an honest recollection. In reaching this decision, it accepts the Legal Assessor's advice that the giving of evidence is not a test of memory, a test which a witness must pass or fail. Memories fade over a period of time and the longer the period over which recollection is made, the greater the likelihood that errors will emerge. As long as the Panel is satisfied that the witness is a truthful witness, it is right to give an appropriate allowance, where inaccuracies are found, for the frailty of the human mind to recall events of long ago exactly as they took place.

The Panel notes and accepts that Nurse C drew no distinction between the words recorded by Nurse D in the Kardex, "encouraging urinary output", and the wording in the head of charge, namely, "until Patient A had passed urine".

Nurse C's evidence of the instruction she received concerning the input of fluids and the evidence you gave about your instruction to her are mutually inconsistent. Nurse C, when giving evidence, referred to the written account she had given many years ago as being an accurate recollection of events. She placed little reliance on her recollection independent of that account. She was unwilling or unable therefore to move away from that position when exposed to proper cross-examination. This exemplifies how difficult it is to deal, with any high degree of confidence, with evidence of facts being brought to mind after such a long interval.

For these reasons, the Panel is unable to regard as belligerent or truculent Nurse C's refusal to agree with propositions put to her in cross-examination so many years after the event.

The Panel has had regard to these inherent difficulties and your own failure, at the time, to make any attempt to ensure that Nurse C had correctly heard and understood your instruction. Mindful of the standard of proof required, the Panel cannot be satisfied, so as to be sure, that what Nurse C recalled and recorded several years ago was, in fact, what you told her.

Heads 4(a) and (b) have been found proved.

The Panel is of the view that these heads of charge accurately reflect the words used in your record and the Panel is therefore satisfied, so that it is sure, that they are made out.

Head 5(a) has been found proved.

The Panel is satisfied, so that it is sure, that your record was inaccurate by reason of its incompleteness. The Panel rejects your contention that, in a paediatric setting, a bolus can only relate to a dose of Normal saline. A bolus is a generic description of a style of administration and in no way identifies the substance to be administered. Indeed the Panel notes, by way of example, that in answer to a question from a panel member, you accepted that a prescription for mannitol, 5g intravenous, over half an hour, was a bolus.

Head 5(b) has been found proved.

Given that the Panel has found that your record was inaccurate, it is satisfied so that it is sure, that it was also misleading.

Head 5(c) has been found not proved.

The Panel is concerned that the record you made in the patient's notes on 14 April 2000 was, for the reasons given, inaccurate and misleading. However, having considered the test to be applied as set out by the Legal Assessor, it cannot be satisfied so that it is sure, that it was also dishonest.

Heads 6(a) and (c) have been found proved.

The Panel take the view that the fact that the fluid regime you claimed to have ordered was not administered gives rise to the inference that it had not been properly communicated. Further, the Panel accepts the evidence of the expert witness that proper communication should have included the writing down of your instructions. You failed to do so. In addition, your record of the fluid regime was inaccurately described. Even if you had accurately described the fluid regime, the Panel accepts the expert evidence that it was not appropriate. For all these reasons the Panel is satisfied so that it is sure that these heads of charge are made out.

Heads 7(a) and (b) have been found proved in relation to heads 2(b), 2(c)(i), 2(c)(ii), 2(c)(iii), 2(c)(iv), 2(d)(i), 2(d)(ii), 2(e), 4(a), 4(b), 5(a), 5(b), 6(a), 6(b) and 6(c).

The Panel did not make any finding in relation to head 3(a) because of its finding at head 3(b).

In reaching these findings the Panel considers that as soon as you arrived on the ward to treat Patient A you became the treating doctor. It was incumbent upon you, in the proper discharge of your duties, to put in place an up to date plan for the patient's care. Your duty was to record this so that others who might be required to attend to the patient would be aware of how the care was to proceed. Before you left the ward you should have ensured that your colleagues understood what was expected of them in terms of monitoring the patient and what to do if things changed. The Panel accepts the view of the expert witness that the only way of ensuring this was to make a clear written record. This was not done.

The Panel accepts the evidence of the expert witness that there would be no criticism of your leaving the ward had you correctly completed your tasks. You left before you had taken all the necessary steps to ensure that nursing staff were aware of, and understood, what was expected of them. This is all the more serious given your concerns about the intravenous line failing. It is the Panel's view that, having failed to properly discharge your duty, you left Patient A in an unsafe environment.

In relation to the record you made on 14 April 2000, of your fluid management plan for Patient A, the Panel considers that your actions in this regard were not in the patient's best interests and fell below the standard to be expected of a reasonably competent Consultant Paediatrician. Your duty of care was not extinguished by Patient A's death. You had an ongoing obligation to ensure that any subsequent notes that you made on her record were neither inaccurate nor misleading.

Having reached these findings the Panel considered whether the facts found proved would be insufficient to support a finding of serious professional misconduct.

The Panel has taken account of the advice of the Legal Assessor who referred to the case of Nandi v GMC [2004] EWHC 2317 (Admin), where Collins J, referring to the question of seriousness, emphasised the need to give it proper weight, observing that in other contexts it has been referred to as "conduct which would be regarded as deplorable by fellow practitioners." The Panel has reminded itself of the evidence of the GMC's expert witness who described your record keeping on this occasion as "dreadful", "deplorable" and "inexcusable". The Panel adopts this view. The death of Patient A followed your failure to ensure that you had made a written record of your plan of care for her. The seriousness of this failure set Patient A on the road to her demise. Whilst the Panel has not found dishonesty on your part, it has concluded that the facts found proved would not be insufficient to support a finding of serious professional misconduct.

The Panel now invites Mr Grundy to adduce any further evidence as to the circumstances leading up to the facts found proved, the extent to which those facts

indicate serious professional misconduct on your part and your character and previous history. Ms Foster on your behalf will be given an opportunity to respond to those matters and adduce any further evidence in mitigation.

The Panel will then consider whether you have been guilty of serious professional misconduct and if so, it will then go on to consider what action, if any, should be taken against your registration.

Determination on serious professional misconduct and sanction

Dr O'Donohoe

The facts found proved by the Panel are as follows:

On 12 April 2000, you were employed as a Consultant Paediatrician at the Erne Hospital, Enniskillen. The Panel has found that you attended, assessed and inserted an intravenous line into Patient A. In carrying out this procedure you did not calculate an acceptable plan of fluid replacement. Furthermore, you did not ensure that a record was made on that day of your assessment and diagnosis, management plan including fluid management plan, calculation of fluid replacement requirements and fluid prescription stating the identity of the fluid and the rate of infusion over time. Neither did you ensure that the nursing staff on the ward knew of an adequate fluid replacement plan or system for monitoring its progress. Further, you did not monitor or check Patient A again prior to a crash call at approximately 3am.

On 14 April 2000, you made a record of what your fluid management plan for Patient A on 12 April 2000 had been, namely, a bolus of 100 mls over one hour, followed by 0.18% sodium chloride / 4% dextrose at 30 mls per hour. The Panel found that your record was inaccurate and misleading.

The Panel has found that the fluid regime as set out in your record was not communicated properly by you to those administering the fluid, not monitored or checked by you to ensure that it was followed and, in any event, was not appropriate.

The Panel has found that your actions in relation to Patient A were not in her best interests and fell below the standards to be expected of a reasonably competent Consultant Paediatrician.

Having reached these findings, the Panel must now consider whether they amount to serious professional misconduct.

Mr Grundy, on behalf of the GMC, submitted that you have breached fundamental tenets of Good Medical Practice. He submitted that these breaches were serious and had serious consequences. He further submitted that they increased the risk of tragedy for Patient A and that you had failed in your duty of care to her.

Ms Foster, on your behalf, submitted that you accept that you have a case to answer in relation to serious professional misconduct. However, she did not concede that

the Panel should automatically reach a finding of serious professional misconduct. In making this submission, Ms Foster referred the Panel to the relevant case law. She submitted that the failings found by this Panel could not be categorised as anything other than an isolated event.

The Panel has taken account of the GMC's publication Good Medical Practice (1998 edition) applicable at the time. Good Medical Practice states under the heading of Good clinical care:

> "In providing care you must:
> …
> - keep clear, accurate, and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed;
> - keep colleagues well informed when sharing the care of patients;…
> - prescribe only the treatment, drugs, or appliances that serve the patient's needs…"

Under the heading of Working in teams, it states:

> "If you lead the team you must:
>
> - take responsibility for ensuring that the team provides care which is safe, effective and efficient."

It further states:

> "When you work in a team you remain accountable for your professional conduct and the care you provide."

Under the heading of Delegation and referral, it states:

> "Delegation involves asking a nurse, doctor, medical student or other health care worker to provide treatment or care on your behalf. When you delegate care or treatment you must be sure that the person to whom you delegate is competent to carry out the procedure or provide the therapy involved. You must always pass on enough information about the patient and the treatment needed. You will still be responsible for the overall management of the patient."

The Panel has determined that the care you provided to Patient A was not in her best interests and fell below the standard to be expected of a reasonably competent Consultant Paediatrician. Good Medical Practice sets out the principles and standards expected of all registered medical practitioners. You breached those set out above.

The Panel has borne in mind the submission that this was a single event. It has reminded itself of the advice of the Legal Assessor who commended to the Panel the

case of Silver v GMC (Privy Council Appeal No. 66 of 2002), where Sir Philip Otton stated:

> "In the instant case there can be little doubt that there was negligence and that it was open to the Committee to find that this constituted professional misconduct. However the Committee should have gone on to consider as a separate issue whether this amounted to serious professional misconduct. It is by no means self-evident that if this question had been posed it would have been answered in the affirmative. It was relevant to consider that this was an isolated incident relating to one patient (albeit over a number of days) as compared with a number of patients over a longer period of time."

At Ms Foster's invitation, the Panel has carefully considered the context of the case, and it agrees with her that, within that context, this might be considered a borderline case of serious professional misconduct.

Having considered all the evidence, the Panel has taken account of the fact that your misconduct related to one patient over a relatively short space of time, and not to a number of patients over a longer period of time. However, the potential consequences of your misconduct were serious and placed that patient at an unnecessary risk of harm.

The Panel has considered the public interest. The public interest includes the protection of patients, the maintenance of public confidence in the medical profession and the declaring and upholding of proper standards of conduct and behaviour. You failed in each of these and this, coupled with your breaches of Good Medical Practice, has led the Panel to determine that you have been guilty of serious professional misconduct.

The Panel next considered what sanction, if any, it should impose in relation to your registration.

Mr Grundy, on behalf of the GMC, referred the Panel to the GMC's Indicative Sanctions Guidance (May 2004), and reminded the Panel that if it made a finding of serious professional misconduct it would be open to it to conclude the case and issue you with a reprimand. However, he submitted that this case is not one that should be considered at the lower end of the spectrum of serious professional misconduct and that suspension is the appropriate and proportionate sanction. In making this submission he referred the Panel to the most recent version of the GMC's Indicative Sanctions Guidance (April 2009, with August 2009 revisions).

Ms Foster, on your behalf, also referred the Panel to the GMC's Indicative Sanctions Guidance. In particular she drew to the Panel's attention paragraph 26, which states:

> "The Panel should also take into account matters of personal and professional mitigation which may be advanced such as testimonials, personal hardship and work related stress. Without purporting in any way to be exhaustive, other

factors might include matters such as lapse of time since an incident occurred, inexperience or a lack of training and supervision at work. Features such as these should be considered and balanced carefully against the central aim of sanctions, that is the protection of the public and the maintenance of standards and public confidence in the profession."

Ms Foster submitted that what the Panel might have thought was an appropriate sanction ten years ago should now be mitigated by the lapse of time. She emphasised that this was a single patient and a single incident and that there is no indication that anything similar had ever taken place before nor had it been repeated. It is her submission that it is of considerable importance to the Panel that there has been a lesson learned, and that this is evidenced by the steps you have taken with regard to your own note taking, the new systems you have been involved in establishing on the ward and your continuing awareness of the need for care and diligence.

Ms Foster submitted that you are a careful, insightful and respected doctor. She stated that you made one mistake that contributed to disastrous consequences and she invited the Panel to give weight to the efforts that you have undertaken to prevent any possible repetition.

It is Ms Foster's submission that, in the context of almost ten years of unblemished practice since the matters found against you, it would be unlawful to suspend you from practice; the Legal Assessor advised the Panel that this was not the case.

The Panel has considered the submissions of both Counsel and notes that the matter of sanction is one for it to determine exercising its own judgement.

The Panel has considered the testimonial evidence in this case and has taken account of the written testimonial of Dr E and also the evidence of Dr F and Mr G who both gave oral testimony via video link.

In determining what sanction, if any, it should impose, the Panel has borne in mind all the GMC's Indicative Sanctions Guidance referred to in submissions.

The Indicative Sanctions Guidance states that the purpose of sanctions is not to be punitive but to protect patients and the wider public interest, although they may have a punitive effect. The Panel has also borne in mind the principle of proportionality, and has weighed the interests of the public with your own interests.

The Panel first considered whether to conclude this case by taking no action. Mindful of its duty to act in the public interest, the Panel determined that this would not be a sufficient response.

The Panel then went on to consider the mitigating circumstances. The fact that a period of almost ten years has elapsed since the events in question has weighed heavily with the Panel. It found the testimonial evidence, particularly from Dr F, compelling in terms of the difficulties and pressures in the working environment at that time. Whilst this does not diminish your duty to have ensured that you made

yourself aware of the working practices within the Paediatric Department, it does provide some context and the Panel has taken account of this.

The Panel has heard about the corrective steps you have taken within the Department and the guidance and protocols which you have developed and introduced in order to prevent any recurrence. This demonstrates a degree of insight into the matters which have brought you before this Panel and identifies the lessons you have learned.

However, the Panel is bound to consider most carefully whether the public interest demands that a period of suspension is the only appropriate and proportionate sanction.

The public interest clearly includes ensuring that patients and members of the public can have confidence in the profession. The Panel has carefully considered what useful purpose a period of suspension would serve. A period of suspension would send a signal to the profession and members of the public of what the Panel considers to be behaviour unbefitting a Consultant Paediatrician.

The Panel is confident that you do not pose a real and present risk to patients and the evidence before it is that you are a competent and useful doctor who provides a valuable service within the community. The Panel is satisfied that a finding of serious professional misconduct is a message in itself, which marks its disapproval of the matters found proved.

The Panel notes that the public interest must also include a reluctance to deprive the profession of an otherwise competent and useful doctor who presents no danger to patients and members of the public.

In all the circumstances the Panel has determined that suspension would not now be proportionate. Had the Panel considered this case shortly after the events in question, its decision may well have been different.

The Panel has therefore determined that it is proportionate and appropriate to conclude your case with a reprimand.

That concludes the case.

Confirmed

30 October 2009 Chairman