(The Panel continued to deliberate in camera)

STRANGERS HAVING BEEN READMITTED

THE CHAIRMAN: Good afternoon, everybody. I did tell you that my estimates are not to be relied upon, but we have reached the point that we needed to.

DETERMINATION

THE CHAIRMAN: 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 Evans, 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 Swift 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 Swift drew no distinction between the words recorded by Nurse McManus in the Kardex, "encouraging urinary output", and the wording in the head of charge, namely, "until Patient A had passed urine".

Nurse Swift'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 Swift, 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 Swift'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 Swift 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 Swift 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.

Mr Grundy.

MR GRUNDY: Sir, I did have a discussion with my learned friend. There are perhaps two matters. One, I think she indicated to me she would appreciate just a few moments to speak to the doctor about the determination. Secondly, I understand she has two witnesses lined up this afternoon and I indicated that rather than keeping witnesses at the end of a video link it might be sensible to take them out of order, so to speak; in other words, you hear the witnesses, I assume they are testimonial witnesses, and then I will make my submissions to you.

THE CHAIRMAN: Ms Foster, I am sure the Panel would have no objection to that, but our understanding, which may be wrong, is that the first, video link witness was due to arrive at the video link station at two o'clock, so in fact we would appear to have time.

MR GRUNDY: I was told two o'clock.

MS FOSTER: It was two o'clock until we were put back, yes, sir.

THE CHAIRMAN: So it has been adjusted, fine.

MS FOSTER: It has been adjusted. I think in fact I indicated I thought it was likely that if they were needed they might be needed at about 3.15, but please turn up for three o'clock. That is the position.

THE CHAIRMAN: I would hope we would be ready by three, but if you would like to take some time now to make sure the doctor understands what has been ---

MS FOSTER: I would like to take some time now, please. Yes, indeed. I think it would be very appropriate. If you would be good enough to give us until three o'clock, maybe just before.

THE CHAIRMAN: That long?

MS FOSTER: I will check. *(Pause)* Fifteen minutes.

THE CHAIRMAN: I am not going to get into negotiations. My point simply is that we are all trying very hard to make sure that we do not run out of time tomorrow and my initial thought was explaining briefly what this determination means to the doctor was not a great issue, but if you think 15 minutes will serve then we will say 15 minutes. Mr Grundy, would you be started and finished within a period of about 15 minutes?

MR GRUNDY: Yes.

THE CHAIRMAN: Then we would go straight to you in the normal way.

MS FOSTER: Indeed, thank you.