(The Panel continued to deliberate in camera)

STRANGERS HAVING BEEN READMITTED

THE CHAIRMAN: Good afternoon, everybody.

DETERMINATION

THE CHAIRMAN: 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 3.00 a.m.

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.

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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.

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

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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.

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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.

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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":

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"In providing care you must:

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...

- 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:

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"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."

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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.

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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:

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"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

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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."

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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.

C

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.

D

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.

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

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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

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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 Raza and also the evidence of Dr Marshall and Mr Geddes 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 Marshall, 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

A to the profession and members of the public of what the Panel considers to be behaviour unbefitting a Consultant Paediatrician.

B 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

C proved.

The Panel notes that the public interest must also include a reluctance to deprive the

D 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

E proportionate. Had the Panel considered this case shortly after the events in question, its decision may well have been different.

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

G That concludes the case.

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